



Transitions 2002

A 5-YEAR INITIATIVE TO RESTRUCTURE INDIAN HEALTH



Final Report of the Restructuring Initiative Workgroup



Prepared for the Indian Health Service October, 2002



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A LETTER FROM THE CO-CHAIRS

As co-chairs for the Transitions 2002 Restructuring Initiative Workgroup (RIW), we thank the Indian Health Service (IHS) for ensuring the voice of American Indian and Alaska Native people is heard in designing and restructuring the health care delivery system that serves them.

The Interim RIW report that was distributed to Indian Country in June 2002 addressed the Department of Health and Human Services (HHS) proposals to consolidate portions of the IHS into HHS. Because reforms in recent years had downsized the IHS administrative work force by more than half, we did not endorse HHS proposals. The main concern is that consolidation within HHS will reduce resources for Indian health and make Indian health disparities and funding gap worse, not better. The interim report offered alternatives to achieve HHS policy goals without loss of resources from the IHS. We also proposed a 5-year initiative to eliminate Indian health disparities beginning with steps to double funding to bring Indian health care resources in line with other Americans.

Since June, we have continued exploring detailed options for what the Indian health care system should look like in 5-7 years. Our final report recommends a new balance among treatment and rehabilitation, disease prevention, and public health programs. To prepare for this new balance, reforms of the work force, facilities, technological infrastructure, and administrative support systems are identified. A key principle is reinvestment of all restructuring "savings" to expand services to the already underserved Indian population. Among options for the next 5 years is regionalization of some administrative functions, streamlining facilities design, augmenting technology infrastructure, incorporating successful business practices, and measures assisting Tribes obtain all resources for which they are eligible.

We provide this report to the IHS with an understanding that its recommendations will be made available for consultation with Indian Country. The next big step is for the IHS to consult with tribes, Indian health organizations, and Indian people and consider all views and suggestions before adopting any recommendations that affect the Indian health care system.

We considered complex issues and difficult challenges. We have worked hard to fulfill our charge to "recommend design changes to IHS that will advance the health of all Indian people by considering representative views from throughout Indian Country." Given the time available to us, we believe we have come up with a realistic guide for change. Even though our part is nearly done, the process is far from over. Consultation undoubtedly will produce even more ideas for consideration and much work to develop detailed transition plans remains.

On behalf of all the Workgroup members, we extend our appreciation to the people of Indian Country. Representing you was a great honor.

Joseph A. Moauino

Council Member, San Juan Pueblo

Tribal Co-Chair

Athleen R. annetts M.D. Director, Bemidji Area IHS

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GLOSSARY OF ACRONYMS

ADPL Average Daily Patient Load (inpatients)
AIAN American Indians and Alaska Natives
CDC Centers for Disease Control and Prevention

CHS Contract Health Services

CMS Center for Medicare and Medicaid Services (formerly HCFA)

CO Commissioned Officers (a federal personnel system)

CS Civil Service (a federal personnel system)

DOD Department of Defense

EPA Environmental Protection Agency

EPI Epidemiology

ES Engineering Services

FAAB Facilities Appropriation Advisory Board (a joint tribal/IHS workgroup)
FDI Federal employee health plan Disparity Index (formerly LNF index)

FEHP Federal Employee Health Plan

FTE(s) Full-time equivalents

FY Fiscal Year

GPRA Government Performance Results Act
HHS Department of Health and Human Services

HHS Health Insurance Portability and Accountability Act of 1996

HQ IHS Headquarters HR Human Resources

HSP Health Systems Planning

HUD Department of Housing and Urban Development

IHS Indian Health Service

IHCIA Indian Health Care Improvement Act

IHDT Indian Health Design Team

ISAC Information Systems Advisory Council (a joint tribal/IHS workgroup)

IT Information Technology

I/T/U "I" stands for programs delivered by IHS, "T" stands for programs

delivered by Tribes through compacts or contracts, and "U" stands for Urban Indian

Health programs.

LNF Level of Need Funded—Study comparing IHS funding to health insurance costs

NCHS National Center for Health Statistics
OMB Office of Management Budget

RFP Request for Proposal (for grants typically)

RIW Restructuring Initiative Workgroup RRM Resource Requirements Methodology

TA Technical Assistance

TANF Temporary Assistance for Needy Families

Title XIX Grants to States for Medical Assistance Programs—a title of the Social Security Act

US United States

VA Department of Veterans Affairs

EXECUTIVE SUMMARY



"Transitions 2002: A 5-Year Initiative For Restructuring Indian Health" contains recommendations for reforms within the Indian Health Service (IHS) to enable accessible and acceptable health care services for American Indians and Alaska Natives during the next five years. Recommendations were developed by the Restructuring Initiative Workgroup (RIW), a constituent-dominated group of 20 Indian health leaders.

The June 2002 Interim RIW report addressed the Department of Health and Human Services (HHS) proposals to consolidate portions of the Indian health care system into HHS and how IHS reforms relate to the President's Management Agenda. Because reforms in recent years had downsized the IHS administrative work force by more than half, the RIW did not endorse HHS proposals. The main concern is that consolidation within HHS will reduce resources for Indian health and make Indian health disparities and funding gap worse, not better. The interim report offered alternatives to achieve HHS policy goals without loss of resources from the IHS. The interim report also proposed a 5-year initiative to eliminate Indian health disparities beginning with steps to double funding to bring Indian health care resources in line with health care resources available to other Americans.

The RIW has continued exploring more detailed options for what the Indian health care system should look like in 5-7 years. The RIW final report recommends reforms to address the lingering health disparities experienced by Indians including a new balance among treatment and rehabilitation, disease prevention, and public health programs. To prepare for this new balance, reforms of the work force, facilities, technological infrastructure, and administrative support systems are identified. The key principle is reinvestment of all restructuring "savings" in front line health care programs to expand services to the underserved Indian population. Among options for the next 5 years is regionalization of some administrative functions, streamlining facilities design, augmenting technology infrastructure, incorporating successful business practices, and measures assisting Tribes to realize resources for which they are eligible.

Section one, "Guiding the Indian Health Care System through Transition," describes a continuing partnership in which stakeholders are directly engaged in shaping plans that affect health care programs in Indian Country

Section two, "Core Principles in Indian Health," identifies eight principles to American Indians and Alaska Natives that are important in the context of their health care system. They are:

- A Health Care System for Indian People
- Tribal Sovereignty
- Federal Trust Responsibility
- Government-to-Government Relationship
- Tribal Consultation
- Self-Determination
- Pre-Paid Health Care
- A Special Appropriation for a Special Mission

Adequate tribal consultation in advance of making changes that affect Indian communities is required.

Section three, "Troubling Disparities—Unequal Health Care," describes health conditions and needs of the American Indian and Alaska Native people. The Indian people differ dramatically from other Americans in two ways. First, they experience a substantially lower health status and greater mortality and morbidity as compared with U.S. All Races. Second, they have dramatically less per capita health care expenditures as compared with U.S. All Races. The RIW has concluded that filling in resources gaps and improving access to health care services is essential to eliminate the health disparities experienced by Indian people. Therefore, the RIW recommends that the IHS budget be increased to \$5 billion by 2007.

Section four, "Recent Reforms in IHS," describes restructuring already accomplished. Before making plans for the future, it is wise to examine the past. The IHS began serious reorganization in the mid-1990s that has reduced the administrative workforce by more than half. The IHS downsized to a greater degree than other agencies within the HHS.

Section five, "One-HHS Proposals and The Presidents Management Initiative," addresses proposals to consolidate portions of IHS into HHS. Because the IHS had downsized previously, the RIW recommends that the IHS be exempt from proposals for work force reductions and consolidations. The main concern is that consolidation of IHS functions within HHS will reduce resources for Indian health and make the disparities and funding gap worse, not better. The RIW offers alternatives that will lessen the concerns and serve to creatively and constructively participate in the One-HHS initiative while resisting a loss of resources to Indian health. Solutions can be found if the HHS first consults with American Indians and Alaska Natives in accordance with the HHS Tribal consultation policy.

Section six, "A Vision for Health – Eliminate Disparities and Sustain Wellbeing," describes a vision for the future. Achieving health and well-being for American Indians and Alaska Natives first requires the elimination of heath disparities they have long experienced, beginning with doubling the per capita funding for Indian health. The second part goes beyond Indian people having equivalent medical resources and treatment to sustaining health and well-being by living in accordance with Tribal cultural principles.

Section seven, "A Look 5 Years into the Future," examines impacts of broad trends on the Indian health care system and explores options for what it should look like in 5-7 years. It recommends a new balance of treatment and rehabilitation, disease prevention and wellness, and public health programs.

Section eight, "Internal Restructuring Reforms," recommends options for internal reforms of the Indian health care system to prepare the Indian health system workforce, facilities, technological infrastructure, and administrative support systems to fit the new balance of patient and community programs. One conclusion is IHS' administrative structure and practices must fully adapt to the reality of significantly less resources. The RIW proposes a realignment of some administrative functions into regional teams that could improve support to front line health programs and potentially save 100-150 FTE that could be converted into nurses and other health care workers to expand services to Indian people. Other internal reforms include streamlining the facilities construction and engineering process, enhancing information technology infrastructure, incorporating successful business practices, and investing in measures to assist Tribes realize all resources for which they are eligible.

Finally, the Appendix, "Comment on the Interim Report," summarizes the comment received from tribes and Indian health leaders about the Interim RIW report. The RIW used the feedback about the Interim Report to revise and improve the final report.

SUMMARY OF RECOMMENDATIONS

The recommendations listed in the summary are extracted from the full text of the RIW report. Please refer to the relevant sections for a full explanation, context, and rationale.

Recommendations to Uphold Core Principles and Responsibilities to American Indians and Alaska Natives

- 2.1 The Administration, Congress, and Federal agencies must recognize the sovereign status of Indian Tribes.
- 2.2 The HHS must expand its services into American Indian and Alaska Native communities as a part of carrying out the Federal trust responsibility for health care services to Indian people.
- 2.3 The position of IHS Director must be elevated to the Assistant Secretary level within HHS to strengthen the government-to-government relationship between the United States and Tribes.
- 2.4 The President must appoint a liaison in the White House for Tribal Leaders and Indian organizations to 1) inform the Administration on the status of Tribes, 2) assist the Administration in addressing the consultation directives and policies related to American Indian and Alaska Native people and their communities, and 3) explore ways to address Indian issues.
- 2.5 The HHS Secretary must provide to Tribal Governments direct eligibility for HHS grants and access to funds from other HHS agencies that are normally reserved only for states.
- 2.6 The HHS Secretary must issue a directive that all savings derived from IHS restructuring be exclusively reinvested in IHS mission-related activities.
- 2.7 The HHS Secretary must issue a letter about the One-HHS initiative to Tribal Leaders to initiate Tribal consultation.
- 2.8 The HHS Secretary must activate the Intradepartmental Council on Native American Affairs.
- 2.9 The HHS Secretary must regularly meet with Tribal Leaders to address how HHS can better address Indian health issues.
- 2.10 The HHS Secretary must exempt the IHS from full-time equivalent (FTE) and budget reductions since the Agency is under funded and had recently restructured in order to shift administrative resources to direct services in communities where Indian people are served.
- 2.11 Tribes must be consulted about the IHS/HHS/OMB budget early in the formulation process.
- 2.12 The IHS and HHS must consider the recommendations of the IHS/Tribal Public Health Support Workgroup and the Strategic Plan Workgroup.
- 2.13 The IHS and HHS must advocate for the Indian Health Care Improvement Act to become permanent legislation.
- 2.14 The IHS must clarify its Patient Bill of Rights to ensure both a high quality and level of services for American Indian and Alaska Native patients.

Recommendation to Revise the IHS Foundation, Mission, and Goals

4.1 Adopt the proposed foundation, mission, and goal statements to replace the existing statements.

Recommendations to Address the "One-HHS" Restructuring Initiative

- 5.1 Maintain Legislative and Public Affairs staffs in IHS to ensure that HHS gets timely information from and well-informed analysis about Indian Country.
- 5.2 The IHS Legislation and Public Affairs staffs will coordinate closely with other HHS agencies in national emergencies and on cross-cutting issues to ensure cohesion of the HHS message.

- 5.3 Use performance contracts and inter-agency agreements to ensure IHS accountability to the Secretary for a cohesive approach to legislation and public information.
- 5.4 Realign Human Resource (HR) support functions <u>within</u> IHS to take advantage of new technologies and enhance expertise available to all IHS sites in 35 States.
- 5.5 Avoid consolidating IHS' specialized experience and support for the dispersed community-based health care system with highly dissimilar agencies.
- 5.6 Implement operational improvements with the IHS to achieve performance goals envisioned by the Secretary.
- 5.7 Retain the IHS health care facilities and sanitation construction programs within the IHS to ensure its mission-critical focus is maintained.
- 5.8 Endorse HHS steps to better manage federal office space that does not impact front-line Indian health care facilities.
- 5.9 Use a memorandum of agreement to ensure full reporting and compliance of IHS facilities data with HHS standards.
- 5.10 The HHS should support increased funding to address aged and inadequate health facilities in Indian Country.
- 5.11 Ensure that IHS reforms accommodate and affirm Tribal rights to compact, contract, or retain IHS to operate health programs directly.
- 5.12 Track all realigned resources to ensure that resources available to the Tribes (known as Tribal shares) are not reduced as consequence of reforms.
- 5.13 Apply all savings resulting from restructuring to additional health care services for Indian people.
- 5.14 Fully fund contract support costs and other one-time costs of transition to remove the impediment for additional Tribal contracting and compacting.
- 5.15 Assess the structure and capacity of the Office of Tribal Programs, headquarters direct support programs, and the IHS Urban Indian Health Program Office to complement the assessment already completed for the Office of Tribal Self-Governance.
- 5.16 Assure a balanced capability among these offices in accordance with the actual mix of selfdetermination contracts and compacts, IHS direct programs, and Urban Indian Health Programs.
- 5.17 Identify contingency plans to minimize service disruptions for any tribe potentially affected by retrocession of a contract or compact to the IHS.
- 5.18 Manage transfer of Tribal shares to ensure a smooth and orderly transition of programs, activities, functions, and services to all Tribes.

Recommendations to Eliminate Indian Health Disparities and Sustain Wellness for Indian People

- 6.1 Double IHS funding on a per capita basis to bring resources for Indian health in line with those available to other Americans.
- 6.2 Ensure eligibility for Tribes and urban Indian health organizations to access and share in health care resources of other HHS agencies.
- 6.3 Double the number health care providers in the Indian health care system.
- 6.4 Eliminate shortages of doctors, dentists, pharmacists, nurses and other health care providers in Indian Country through better recruitment, training, and compensation.
- Replace, expand, and modernize aged inadequate hospitals and ambulatory clinics for a growing Indian population.
- 6.6 Invest in community infrastructure, especially for safe water supply and waste disposal—forms infrastructure that are virtually non-existent in remote areas of Indian Country.
- 6.7 Encourage and support traditional Tribal healers, cultural practices and principles;
- 6.8 Emphasize Indian beliefs, ceremonies, and traditional practices of harmony and health as grounding for individual identity and personal self-worth especially for young people;
- 6.9 Devote appropriate resources to wellness and prevention programs targeted to lifestyle including diet, exercise, and the avoidance of risky behaviors;

- 6.10 Recognize the whole person, extending to family, clan, Tribe, economic, and spiritual elements;
- 6.11 Reinforce Tribal values that encourage healthy choices and discourage harmful activities;
- 6.12 Support Tribal governance and infrastructure to provide a stable basis for community and individual development;
- 6.13 Build a viable economic base for employment in Indian communities, sustainable income, and means for self-support;
- Renew a healthy environment, in conjunction with other Federal agencies, by correcting environmental damage (toxic waste, dioxins in rivers, etc.) and preserving opportunities for hunting, fishing, and gathering from the land, rivers, and seas much as Indian people have done for thousands of years.

Recommended Focus Areas during the next 5-7 Years

- 7.1 Make disease prevention the key objective
- 7.2 Focus on behavior and lifestyle
- 7.3 Strengthen public health capacity
- 7.4 Invest in information technology
- 7.5 Workforce: re-examine the mix, strengthen recruitment and retention
- 7.6 Adapt facilities for a broader approach to health
- 7.7 Adapt administrative support capacity to emerging trends
- 7.8 Reinforce linkages among I/T/Us
- 7.9 Assure that administrators are knowledgeable about healthcare
- 7.10 Market as the "system of choice"

Recommended Internal Reforms during the next 5-7 years

- 8.1 Realignment will improve consistency, quality, and timeliness of administrative support to front line health programs.
- 8.2 A regional configuration offers the best combination of potential savings, improved support service, and lower transition costs.
- 8.3 No IHS Area Office will close.
- 8.4 It is not feasible or appropriate to regionalize all administrative functions.
- 8.5 Combined savings of approximately 100-150 FTE and approximately \$5 million \$7.5 million can be realized by realigning some administrative functions into regional teams.
- 8.6 Direct all savings from regionalization (estimated at 100-150 FTE and \$5-\$7.5 million) into health care services for Indian people.
- 8.7 Preserve and track every Tribe's "shares" of realigned FTE and resources.
- 8.8 Honor existing commitments that obligate Area Offices or headquarters to provide support services in a fashion specified in a binding agreement.
- 8.9 Regionalize appropriate administrative functions in a phased incremental fashion designed to avoid disruptions, develop and test new operational methods, and minimize conversion costs and employee relocations.
- 8.10 Phase-One: In-Place Regionalization: Begin regionalizing administrative organizational structures, span of support, and operational practices to create regional support teams "In-Place."
- 8.11 Phase-Two: Regionalization With Geographic Co-Location of Staff: After a period to develop and implement new regional support teams, and if initial results from phase-one are unsatisfactory, relocate appropriate administrative staff into 3 regional support centers.
- 8.12 The RIW endorses IHS patient workload benchmarks for determining the size and type of facility based on patient workload and population.

- 8.13 When applying patient workload benchmarks to plan new or replacement facilities, consider community input as an additional factor and maintain some planning flexibility consistent with assuring a safe and cost effective facility.
- 8.14 The RIW endorses the Facilities Appropriation Advisory Board (FAAB—a joint IHS/Tribal facilities construction workgroup) process for modifying the IHS facility construction priority system including necessary tribal consultation before adopting revisions to the priority system.
- 8.15 The most significant obstacle in addressing facility deficiencies is the lack of resources for construction.
- 8.16 The RIW does not recommend further consolidation or dispersal at this time of engineering functions now located in Dallas and Seattle.
- 8.17 The RIW recommends further study of whether Indian Country will benefit if the IHS assumes a "leadership" role for some HHS facility and engineering functions.
- 8.18 The RIW endorses no-cost measures to streamline planning, design, and construction as proposed by the IHS.
- 8.19 Adopt and implement a new IHS business Plan when delivered by the Business Plan Workgroup.
- 8.20 Develop a coordinated approach to Bio-terrorism that participates with and shares bio-terrorism preparedness resources from other Federal and State agencies.
- 8.21 Triple investment in information and communications technology over the next five years.
- 8.22 Create an interconnected Indian Health Network for hundreds of widely dispersed health care sites to more effectively collaborate and pool information, expertise, and resources.
- 8.23 Standardize data systems and protocols to assure all locations work together using common standards for communication and interoperability.
- 8.24 Specify hardware and software standards to assure all sites maintain compatibility while preserving flexibility to select differing hardware.
- 8.25 Utilize compatible information systems developed in the larger, better funded federal health care systems such as Department of Defense and Department of Veterans Affairs.
- 8.26 Develop a national data warehouse where consolidated data is retrievable from all sites throughout the Indian Health Network.
- 8.27 Expand technical assistance capability within the IHS environmental health program by creating Environmental Safeguards Technical Assistance Teams.
- 8.28 Reconsider the user count definition employed in IHS resource allocation formulas to account for costs in all facilities used by the patient.
- 8.29 The IHS executive leadership will work to persuade the Secretary to make Indian Country a very high priority for the Presidential priority of eliminating health disparities.
- 8.30 The IHS will work with sister HHS agencies to identify their role and responsibilities to eliminate health disparities of Indian people and seek concrete commitments to fund programs for eliminating those disparities.
- 8.31 Charge the Interdepartmental Council for Native American Affairs with identifying former IHS and tribal employees in DHHS regional offices to be included in tribal issues workgroups and to advocate for Indian issues.
- 8.32 Charge the Interdepartmental Council for Native American Affairs with drafting and recommending to the Secretary an element to include in all HHS agency director's annual performance contracts, specifying target resource amounts to be dedicated for use in Indian country.
- 8.33 Assign senior IHS employees to other HHS agencies to pursue policy support and funding for Indian needs.
- 8.34 Pursue legislation to remove barriers (Title XIX) that prevent Tribes from contracting directly.
- 8.35 Establish a Center for Tribal Access to Resources chartered to assist Tribes to realize all resources for which they are eligible.

1



GUIDING THE INDIAN HEALTH CARE SYSTEM THROUGH TRANSITION

Since 1995, the Indian Health Service (IHS), guided by the American Indian and Alaska Native people it serves, has been adapting to a changing environment by maintaining its strengths and responding, as necessary, to opportunities and challenges. In February 2002, the IHS charged a representative group of 20 Indian health leaders to identify changes to the Indian health care system that will best enable accessible and acceptable health care services for American Indians and Alaska Natives during the next five years.

The Restructuring Initiative Workgroup

The Restructuring Initiative Workgroup (RIW) is a group of Indian health leaders representing key stakeholders -- Tribal Leaders, representatives of Tribal and urban Indian health programs and national Indian organizations, and Federal employees. When the RIW met to discuss the Indian health care system, the group focused on the people they represent -- 1.6 million American Indians and Alaska Natives who are members of 560 federally recognized Tribes eligible to receive health care services from IHS or IHS-funded programs. The RIW discussed how to make a positive difference in the health and well-being of the people living in Indian Country. Indian Country means 661 counties on or near reservations and in rural communities in 35 States where many Indian people live. An estimated 332,000 American Indians and Alaska Natives are eligible to use the Title V Urban Indian Health programs at 36 urban sites¹.

Continuing a Partnership Process

The first stakeholder-driven design initiative for the Agency in almost 40 years spanned 18 months from 1995 to 1997 and recommended organizational and structural changes that shaped the current organization. That initiative, known as the "Indian Health Design Team" (IHDT) helped build a tradition in which tribal leaders and stakeholders are directly engaged in shaping plans and policies that affect health care programs in Indian Country.

When the IHDT recommendations were implemented, a new IHS emerged. The new IHS changed its organizational climate, shifted resources and decision making to the local level where services are delivered, and incorporated new and improved ways of doing business for IHS and IHS-funded programs. By including the people it served in the design initiative and implementing the changes they recommended, the IHS reduced the stigma of federal paternalism that has characterized other federal agencies in serving Indian people.

New Challenges are Emerging

A primary concern of RIW members is to avoid being overtaken by external forces and priorities that are different from those of Indian people. More Tribes are taking over their health care programs through Self-Determination contracts and compacts. The health care arena is rapidly evolving, particularly technology, making it costlier and more complicated to provide health care. Costs of caring for elders are growing dramatically. Moreover, alcoholism, substance abuse, and chronic health problems related to economic disadvantages and lifestyles continue to plague many Indian communities. Expectations and funding of Federal agencies evolve with each new Administration. And, fundamentally new threats, such as bio-terrorism, have emerged since the events of September 11, 2001.

When these trends are considered, it is clear that conditions affecting the Indian health care system have changed enough to again plan for the future. It is not time to sit back. The internal and external forces putting pressure on the Indian health care system will not go away if we ignore them. This is an opportunity for Indian country to guide change. If we let this opportunity pass, we run a risk that others will do it for us – maybe in ways that are not in our best interest.

This report, "Transitions 2002: A 5-Year Initiative for Restructuring Indian Health," provides a guide for transitions needed during the next 5 years. Whereas the 1995-97 design effort focused on empowering the local level and downsizing at the top, this effort focuses on realigning the system to carry out its work in a different internal and external environment.

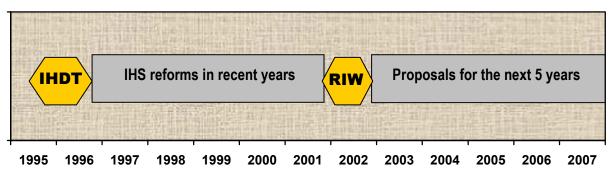


Figure 1.1, IHS Transitions through the Years

Dialogue with Indian Country

The process includes Tribal consultation before IHS takes any actions that affect American Indian and Alaska Native people. By this report, the Workgroup encourages dialogue within Indian Country to address the question: In a changing environment, how will the operators of Indian health care programs continue to provide quality health care to American Indians and Alaska Natives? The answer to this question will emerge after consultation is completed and the Indian people have provided their response to the IHS.

2



CORE PRINCIPLES IN INDIAN HEALTH

The best approach to Indian people requires considering the principles that are important to them. These principles are the lens through which the people of Indian Country see change. In the past, policy makers and decision makers have either ignored or resisted the importance of Indian health principles as they have tried to make Indian people adapt to change. The RIW identified eight core principles in Indian health that are fundamental to meaningful dialogue with American Indians and Alaska Natives. They are:

- A Health Care System for Indian People
- Tribal Sovereignty
- Federal Trust Responsibility
- Government-to-Government Relationship
- Tribal Consultation
- Self-Determination
- Pre-Paid Health Care
- A Special Appropriation for a Special Mission

Figure 2.1, Core Principles

A Health Care System for Indian People

The IHS obtained its unique status under three acts of Congress. The Snyder Act of 1921 is the first and principle legislation authorizing federal funds for health services to federally recognized Indian Tribes. The Act authorizes funds "... for the relief of distress and conservation of health ... [and] for the employment of ...physicians...for Indian Tribes throughout the United States." Next, the Indian Self-Determination and Education Assistance Act of 1975, as amended, gave Tribes the option of either to assume the administration and operation of health services and programs in their communities from the IHS or to remain within the IHS-administered direct health care system. Third, the Indian Health Care Improvement Act of 1976 (IHCIA), as amended, is a health-specific law. It has established the IHS as part of the Public Health Service, as the principal Federal advocate for the health of all Indian people and as the Agency responsible for elevating the health status of Indian people to the highest level possible. This Act was the first of the three laws to address the important needs of American Indians and Alaska

Natives who live in urban areas in addition to those needs of Tribal members who remain on or near their reservations.

All IHS issues have particular requirements of Indian statutory and Constitutional law and must be considered within the special government-to-government relationship between Tribal nations and the Federal Government. Answers and/or advice generally applicable to other Department of Health and Human Services (HHS) agencies cannot be presumed to be applicable to the IHS. As an operator of direct health care services, the IHS must take into account the full scope of legal issues affecting health care providers. In addition to operating the IHS direct health service program, the Agency is also responsible for helping Tribal Governments operate and manage their own health programs. This includes transferring Agency resources to Tribal Governments to support these operations. The IHS must comply with the Federal law on Indian Preference.

In 1955, the IHS was transferred to what was then known as the Department of Health, Education, and Welfare, now known as the Department of Health and Human Services which is one of 14 departments of the executive branch of the Government. Among HHS agencies, IHS is one of the few agencies that deliver directly personal and public health services to its constituents. The Agency's respect for cultural beliefs, blending of traditional practices with a modern medical model, and emphases on public health and community outreach distinguish it. The Agency's respect for cultural beliefs and its blending of traditional and modern practices might serve as a model for indigenous people around the world. Its emphasis on community-based outreach activities might serve as a model for other HHS agencies with less developed outreach models. Its consultation practices could be a model for the entire Federal Government in an era of strengthening community-based services and citizen-centered approaches to delivering services.

Tribal Sovereignty

Tribes are sovereign nations. They are political entities — not a racial classification of people or a special-interest group. Tribal nations, with their own governing structures and political systems, existed long before the Europeans landed on Indian Country shores and the United States was formed. The distinction of Tribes as self-governing entities is mentioned in the Constitution of the United States. After the United States was formed and early in U.S. history (the 18th and 19th centuries), the U.S. Government recognized Tribal sovereignty and entered into more than 800 treaties with Tribes. The purpose of these treaties was mainly to exchange Tribal homeland for protection and federal services. Therefore, the provision of federal services to Indian people has most of its origin in treaties. In addition to treaties between individual Tribes and the United States, federal services were also provided through acts of Congress, statutes, Presidential Directives and Executive Orders, and court decisions. Tribal Leaders have always maintained that Tribal sovereignty is paramount among Indian principles.

Federal recognition acknowledges the Tribe as a government and establishes government-to-government status between the Tribe and the Federal Government. This status also provides members of the Tribe with certain federal services. One of these services is health care.

Federal Trust Responsibility

The protection of the inalienable right to Tribal self-governance is a responsibility of the Federal Government. The legal instruments cited in the preceding section create a Federal Trust Responsibility to American Indians and Alaska Natives and their Tribal Governments. The Federal Government must uphold its trust responsibility.

Indian people are vitally connected to their identity as members of sovereign nations. Federal policymakers must not forget how American Indians and Alaska Natives were forced to give up their homelands for social, medical, and educational services to help form a more perfect union.

Government-to-Government Relationship

The U.S. Constitution recognizes the political status of Tribal Governments and equates their status with the accord provided to foreign nations: "The Congress shall have power ... to regulate commerce with foreign nations ... and with Indian Tribes." Tribes exercise powers of government. They form their own governing systems, determine who belongs to the Tribe, and elect their own leaders. Tribal Leaders, representatives of their nations, expect full, open communication with Federal leaders and expect to be consulted about changes that affect them. When Federal leaders avoid full and open communication with Tribal Leaders or exclude them from dialogue about policy, programs, and services, Indian people interpret that behavior as diminishing the government-to-government relationship. Sensitivity about this relationship is very high among Indian principles because the Federal Government has broken so many promises to American Indian and Alaska Native people.

Tribal Consultation

The special government-to-government relationship ensures that Tribal nations have maximum participation in the direction of federal services to Indian communities. Participation is ensured through Executive Orders, Departmental policy, and Agency policies that establish Federal consultation with Tribal nations. This participation is necessary so that Tribal Leaders can express the needs of Indian communities to Federal leaders and federal service can be responsive to these needs.

Consultation with Tribal nations is to occur when actions are proposed and <u>before</u> actions are taken that affect Indian communities. The HHS policy on Tribal consultation states:

"Consultation is an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process which results in effective collaboration and informed decision making."

The meaning of consultation is to communicate, discuss, and confer in order to make a decision or reach a settlement. This concept is not new to the U.S. Government. The signers of the Constitution referred to the concept of "consent of the governed" which is a cornerstone of a government for and by the people.

Self-Determination

In exercising self-determination, Tribal Governments are empowered to choose the management direction of their health care. They can receive their health care directly from the IHS; contract with the IHS to provide services; or compact with the IHS and have the administrative control, operation, and funding transferred to Tribal Governments. More than half of IHS resources have been contracted or compacted to Tribal Governments. Tribal empowerment through self-determination and self-governance management and delivery of health care will increase in the future. The IHS must continually transition as Tribes exercise self-determination. Since Indian self-determination was enacted, Congress has strengthened the self-determination policy. The Act was originally articulated by President Nixon and signed into law by President Ford.

Pre-Paid Health Care

American Indians and Alaska Native Tribes have pre-paid for health care benefits for their people through the loss of millions of acres of land and other resources. Some of the original treaties specifically state that health care will be provided as a part of the U.S. Government's responsibility. The issue of whether health care services for Tribes is or should be viewed as an entitlement is currently being discussed and considered by a number of national workgroups and committees. It is the position of a number of Tribal Governments that health care was an integral part of their respective treaties between the Tribe and the U.S. Government. The pending reauthorization of the IHCIA would help clarify the role of the Federal Government as it pertains to Indian health care issues. The RIW members believe that the IHCIA should be permanent.

Recent studies have validated the significant health disparities that American Indians and Alaska Natives experience compared with U.S. All Races. The Federal Employees Health Plan (FEHP) Disparity Index Study shows that many Tribes are funded below the 50 percent level of need funding. Given the magnitude of the health disparities and the limited funding, the RIW members believe that this is an excellent opportunity for the IHS to clarify its Patient's Bill of Rights by better defining the quality and level of services that patients can expect.

A Separate Appropriation for a Special Mission

The Congress has set Indian health appropriations and oversight apart from the HHS. Unlike sister agencies within the HHS, the IHS budget is not appropriated as part of the HHS budget. Rather, appropriations for the IHS and several other federal programs for Indian people are connected with Interior and Related Agencies appropriations. Moreover, Congressional direction and oversight of the HHS and the IHS is exercised through separate oversight committees.

The IHS appropriations are specifically for the provision of health care services to American Indian and Alaska Native people. But Federal health care services to Indian people are not funded as an entitlement. Increasing costs from rising inflation and an expanding beneficiary population are not covered automatically. Because the IHS budget competes for limited discretionary appropriations with other federal programs, IHS appropriations have never been sufficient for health care needs in Indian Country. There has been little progress in closing the gap because IHS buying power has not kept pace with the growing beneficiary population of Indian Country. Consequently, this under funded health care system has been unable to eliminate the health disparities experienced by Indian people.

Recommendations to Address the Core Principles

The RIW proposes the following recommendations to help meet the needs for American Indian and Alaska Native health.

- 2.1 The Administration, Congress, and Federal agencies must recognize the sovereign status of Indian Tribes.
- 2.2 The HHS must expand its services into American Indian and Alaska Native communities as a part of carrying out the Federal trust responsibility for health care services to Indian people.
- 2.3 The position of IHS Director must be elevated to the Assistant Secretary level within HHS to strengthen the government-to-government relationship between the United States and Tribes.

- 2.4 The President must appoint a liaison in the White House for Tribal Leaders and Indian organizations to 1) inform the Administration on the status of Tribes, 2) assist the Administration in addressing the consultation directives and policies related to American Indian and Alaska Native people and their communities, and 3) explore ways to address Indian issues.
- 2.5 The HHS Secretary must provide to Tribal Governments direct eligibility for HHS grants and access to funds from other HHS agencies that are normally reserved only for states.
- 2.6 The HHS Secretary must issue a directive that all savings derived from IHS restructuring be exclusively reinvested in IHS mission-related activities.
- 2.7 The HHS Secretary must issue a letter about the One-HHS initiative to Tribal Leaders to initiate Tribal consultation.
- 2.8 The HHS Secretary must activate the Intradepartmental Council on Native American Affairs.
- 2.9 The HHS Secretary must regularly meet with Tribal Leaders to address how HHS can better address Indian health issues.
- 2.10 The HHS Secretary must exempt the IHS from full-time equivalent (FTE) and budget reductions since the Agency is under funded and had recently restructured in order to shift administrative resources to direct services in communities where Indian people are served.
- 2.11 Tribes must be consulted about the IHS/HHS/OMB budget early in the formulation process.
- 2.12 The IHS and HHS must consider the recommendations of the IHS/Tribal Public Health Support Workgroup and the Strategic Plan Workgroup.
- 2.13 The IHS and HHS must advocate for the Indian Health Care Improvement Act to become permanent legislation.
- 2.14 The IHS must clarify its Patient Bill of Rights to ensure both a high quality and level of services for American Indian and Alaska Native patients.



3

TROUBLING DISPARITIES—UNEQUAL HEALTH CARE

A Disadvantaged Population

American Indians and Alaska Natives have not fully shared in America's prosperity. The Indian population is diverse, geographically dispersed, and economically disadvantaged. Inadequate education, high rates of unemployment, discrimination, and cultural differences all contribute to unhealthy lifestyles and disparities in access to health care for many Indian people.

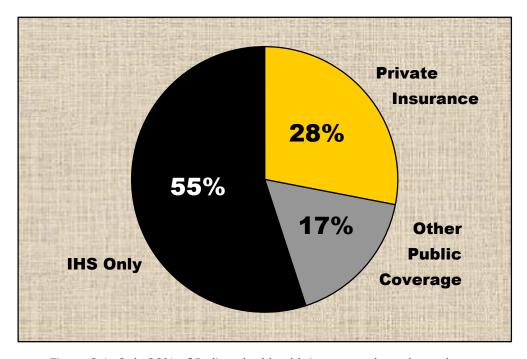


Figure 3.1, Only 28% of Indians had health insurance through employers

American Indians and Alaska Natives are younger and have less formal education and less income than the U.S. population in general. The IHS service population increases at a rate of approximately 2.5

percent per year. The expanding Indian population further taxes the Indian health care system to meet the health needs of Indian Country.

- 32% of Indian people had incomes below the federal poverty standard compared to a rate of 11% for all Americans³
- Unemployment is 2.5 times higher than the U.S. average and exceeds 50% in some reservations
- Many Indian people live in remote places that offer few health care alternatives
- 55% of Indian people rely on IHS as the only source of health care

Progress Interrupted

In decades before the 1990's, health of Indian people improved steadily. The IHS contributed significantly to initial gains by increasing access to health care services, especially by expanding community based primary care, and by intensive public health measures, such as supplying safe water and waste disposal. For almost 40 years, these measures dramatically decreased Indian morbidity and mortality, especially from infectious disease.

Unfortunately, health gains for American Indians and Alaska Natives have slowed or ceased altogether in recent years. Progress in closing the health disparity gap with other Americans has fallen short. People in Indian Country experience health problems and living conditions that shorten their lives by 5.9 years compared to other Americans. An American Indian or Alaska Native born today has a life expectancy of 70.6 years compared to other Americans who on average will live to be 76.5.⁴ The infant mortality rate in Indian Country was 21 percent higher than for other Americans.⁵ The people in Indian Country are dying at rates higher than other Americans.

Alcoholism	670% higher
Tuberculosis	650% higher
Diabetes	318% higher
Unintentional injuries	204% higher
Suicide	92% higher
Homicide	105% higher

Figure 3.2, Indian death rates are higher for many diseases. ⁶

Their lower life expectancy and disproportionate disease burden exists in part because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity or poor social conditions.

Isolation and Inadequate Infrastructure

Many Indian communities are located in isolated reservation areas where inhospitable climate, impassable roads, and populations spread over many miles create major challenges. Among the challenges is providing safe water supply and waste disposal—forms of municipal infrastructure that is virtually non-existent in remote Indian communities. It is a remarkable disease prevention story that the death rate from gastrointestinal disease among Indians has declined by 91 percent by the 1990's as a result of installing basic sanitation facilities and improved access to health care.

But the job is unfinished. Safe water and adequate waste disposal facilities are lacking in 7.5 percent of Indian homes compared with 1 percent of homes in the U.S. general population. In some parts of Indian Country, 35 percent of homes lack these systems. At least 30,000 Indian homes still lack either or both a safe water supply and adequate waste disposal system. These facts represent the poor environmental conditions in which many Indian people live.

When American Indians and Alaska Natives get sick, 62 percent turn to the Indian health care system for health care services. While there are hospitals and ambulatory care facilities in some Indian communities, many Indian people travel long distances to access them. Too often they find the facility old and inadequate for the patient loads generated by the growing Indian population. The average age of Indian facilities is 32 years, with some older than 60 years. Over one-third need replacement. Many need substantial modernization, improvement, and expansion of clinic space. It is difficult to properly support current medical practices in older facilities that were built before the modern emphasis on ambulatory care.

Dramatically Lower Expenditures for Indians

The Indian health care system is intended to provide comprehensive health care services to members of federally recognized Indian Tribes who need them, but health care services are inadequate and vary place to place. Once American Indian and Alaska Native people access the Indian health care system, their per capita personal health care expenditure is lower than that of other Americans (\$1,776 compared to \$4,392 – see Figure 3.3). The American Indians and Alaska Native people receive lower health expenditure per capita than other Federal program beneficiaries receive (see Figure 3.4). Because life-threatening disease and injury get first priority when money runs short, as it often does, patients with lesser problems find their medical care postponed or simply never carried out.

In fiscal year (FY) 2002, the Federal appropriation for the IHS is \$2.8 billion. On a per capita basis, this translates to 55 percent of the cost of mainstream health insurance plans. This disparity severely restricts health care services available to Indian people and is one root cause of the failure to eliminate unacceptable rates of death and disease among American Indians and Alaska Natives. Given the higher health status enjoyed by most other Americans, the health status and health funding disparities of American Indians and Alaska Natives are troubling to Tribal Leaders, health care experts, and policymakers.

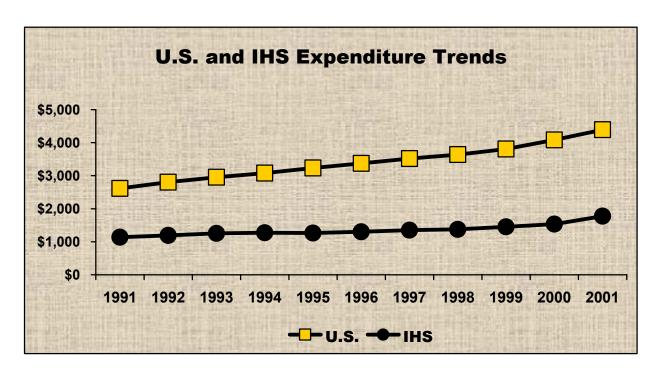


Figure 3.3, Per Capita Health Care Expenditures ¹⁰

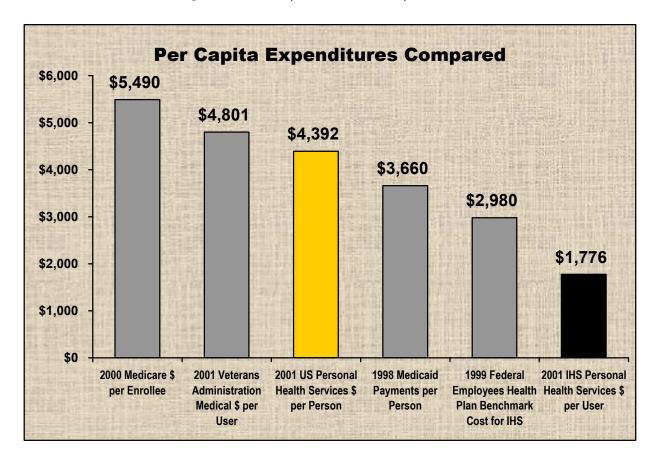


Figure 3.4, Several Benchmarks for Per Capita Health Care Expenditures 11

4



RECENT REFORMS IN THE IHS

The IHS has restructured since 1995 as a result of the first stakeholder-driven design initiative, which recommended organizational changes that shaped how IHS looks today. Before making plans for the future, it is wise to examine the past. This section reviews important changes that IHS has made in recent years to get the job done effectively and efficiently.

Administrative layers downsized

The reference time frame for this Administration's restructuring goals begins in 2002. Members of the RIW believe changes in the Indian health care system prior to 2002 must be considered. Looking back, the IHS has already downsized and redirected FTEs to front line programs.

In looking at the long-term trends (see Figures 4.1, 4.2, and 4.3), it is clear serious reorganization began in the mid-1990s. Administrative layers at the IHS Headquarters and Area Offices were reduced by more than half. The charts on the next page show that IHS has made prudent use of its resources and has redirected savings from administrative downsizing to program services. Because workforce data for tribal health care programs is unavailable, the trends will understate the degree of restructuring since 1995. The addition of tribal workforce data, if available, would augment the upward trend evident for the front-line workforce and draw even greater contrast with the sharp declines at IHS.

The FTE reduction in IHS management layers has been significant and has implications for the extent of additional restructuring that is prudent and practical. The IHS has achieved downsizing during the past 6-8 years and its administrative functions are now about as lean as can reasonably be expected.

As part of the 1995-97 redesign of IHS, Indian leaders specified that IHS' organizational structure should be streamlined and duplicate and unnecessary offices be consolidated or eliminated. Before the redesign, the IHS Headquarters had over 140 individual organizational elements in 8 operational divisions. Today, IHS Headquarters has 40 organizational units aligned into 3 operational divisions. The IHS Headquarters reduced by 100 organizational units and 5 operational divisions. See Chart 4.4: IHS Headquarters Streamlined.

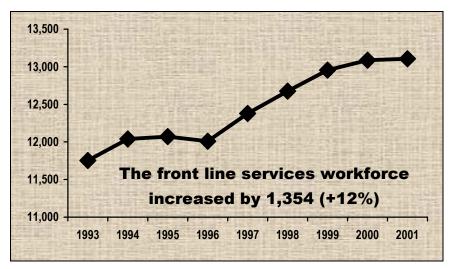


Figure 4.1, Front-line workforce was increased by 12 percent

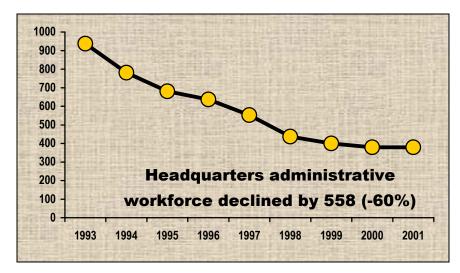


Figure 4.2, HQ ranks were reduced by more than half

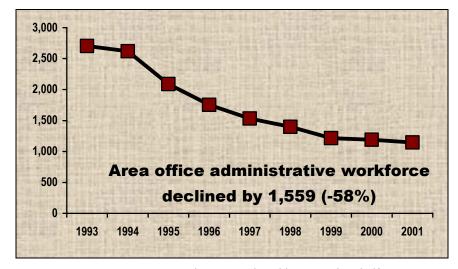


Figure 4.3, Area ranks were reduced by more than half

Eliminated Eliminated or consolidated **IHS** headquarters was reorganized and RETAINED Retained streamlined in 1997. Moved / Realigned MOVED Prof Suppor Congress Liaison

Equally important to the Administration's goals are changes stimulated in IHS by transferring programs and resources to Tribes. By FY 2002, more than half of the IHS budget had been transferred to Tribes. Both IHS front line health care programs and administrative support programs were transferred to tribes through self-determination contracts and compacts. During the last ten years no other HHS agency has experienced the same level of downsizing pressures as those experienced by the IHS.

Downsizing and restructuring of IHS administration will continue as additional Tribes take over IHS functions through self-determination contracts and compacts. The IHS cannot absorb the FTE cuts specified in the FY 2003 IHS budget and simultaneously downsize FTEs required to transfer programs to Tribes over the next few years. The pace and magnitude of the combined reductions are of serious concern to the RIW because of the increased risk of disruptions of services.

Moreover, transfers of FTEs and resources from the IHS appropriation to other HHS appropriations are of great concern. Tribes have the right to contract and compact for IHS resources. Transferring resources and FTEs out of the IHS will diminish these rights. As a consequence, Tribes will have fewer resources available to operate the health programs. The RIW is opposed to FTE and resource transfers that detract from Tribal rights and potential operating resources.

The FTE and resource consolidations proposed by the HHS will actually diminish resources and services to Indian people. This is counter-productive to the Administration's goal to eliminate health disparities for American Indians and Alaska Natives. Health care resources and services must be increased to American Indians and Alaska Native.

Progress Despite Inadequate Resources

Despite the challenges and inadequate resources, Indian health has made progress in achieving its goal to improve the health of American Indians and Alaska Natives. Since 1973, Indian life expectancy has increased by 12.2 years. Mortality rates for American Indians and Alaska Natives have decreased significantly in many areas since 1973. Percentage-wise, the successes are reductions in death rates for:

Tuberculosis	reduced 79%
Gastrointestinal Disease	reduced 91%
Maternal Deaths	reduced 68%
Infant Deaths	reduced 58%
Unintentional Injury	reduced 56%
Pneumonia and Influenza	reduced 52%
Homicide	reduced 40%
Alcoholism	reduced 37%
Suicide	reduced 23%

Figure 4.5, Reductions in Indian Death Rates Since 1973

Build on Progress

Much more must be done to achieve the goal to eliminate the lingering disparities in Indian health status and resources. In this report, the RIW members identify the steps leading to a long-range vision when Indian people do not experience health disparities and the Indian health care system has enough resources. The first step is to review the IHS mission for achieving that long-range vision.

Revised Mission, Goals, and Foundation

It is important to periodically review whether the organization's mission still defines its work and whether its goals still best describe the desired outcomes. The RIW members agreed that the IHS mission must include environmental health because to American Indians and Alaska Natives wellness is a state of harmony and balance among mind, body, spirit, and environment. If the environment is unhealthy, the state of wellness is compromised.

Mission

The mission of the Indian Health Service, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, environmental, and spiritual health to the highest level.

Figure 4.6, Proposed Mission

The IHS should retain the existing goal for providing health services to Indian people and add a goal for eliminating health disparities between American Indians and Alaska Natives and the general population.

Goals

- The Indian Health Service shall provide high-quality, comprehensive, culturally appropriate personal and public health services to all American Indians and Alaska Natives.
- The Indian Health Service shall eliminate all health disparities that exist between American Indians and Alaska Natives and the general population.

Figure 4.7, Proposed Goals

After considering the existing foundation statement, the RIW revised the language to highlight Tribal sovereignty, Trust Responsibility of the Federal Government, and government-to-government relationship between Tribal and Federal Governments.

Foundation

The United States has a unique legal and political relationship with American Indian and Alaska Native Tribes as set forth in the U.S. Constitution, treaties, statutes, Presidential Directives and Executive Orders, and court decisions. These legal instruments create a Federal Trust Responsibility to American Indians and Alaska Natives. This trust responsibility includes, but is not limited to, the protection of the inalienable right to Tribal self-governance and the provision of social, medical, and educational services for American Indians and Alaska Natives. The Department of Health and Human Services shall honor and uphold its Federal Trust Responsibilities and the inherent sovereign rights of American Indians and Alaska Natives.

Figure 4.8, Proposed Foundation

The proposed mission, goals, and foundation statements are the best overall definitive statements for guiding the IHS during the next five years.

4.1 Adopt the proposed foundation, mission, and goal statements to replace the existing statements.

5



"ONE-HHS" PROPOSALS AND THE PRESIDENTS MANAGEMENT INITIATIVE

Part of the charge given to the RIW is to identify how Indian health reforms fit into the President's Management Agenda and the HHS restructuring initiative called One-HHS. The President's Management Agenda is a Government-wide reform to make the Federal Government citizen-centered, results-oriented, and market-based. The RIW members believe the IHS has already addressed many of the President's goals by reforms implemented in recent years.

HHS Consolidation Proposals

The One-HHS initiative consolidates some functions now carried out in all HHS agencies and moves them to the Departmental level. The purposes of One-HHS are to achieve economies of scale, communicate with one voice, and to save money by reducing FTE in all HHS agencies. To save money, the HHS wants to reduce the number of government workers (full-time equivalents or FTE). For IHS, this means a reduction of 100 FTEs by the end of FY 2003 with more to follow in subsequent years. The proposed consolidations of IHS functions into HHS have caused some concern among RIW members. In this report, the RIW shares the concerns of Indian Country and presents some alternatives. The RIW members believe their recommendations respond to the President's Management Agenda overall.

The RIW strongly supports the HHS national goal to eliminate health disparities between American Indian and Alaska Native people and other Americans. The Workgroup's long-range vision for Indian health fits perfectly with this national goal and with the goals of Congress as expressed in the Indian Health Care Improvement Act. However, the HHS initiatives can diminish the goal by decreasing IHS resources, which is already under funded. The consolidations will make the gap worse, not better. The HHS must reconsider any restructuring actions that would result in counter-productive funding reductions for Indians and consider reinvesting some of the HHS restructuring savings to eliminate the funding disparities for Indian health.

The HHS is striving to improve efficiencies, streamline, and build cohesion among all HHS agencies. These goals are appropriate. The RIW understands belt-tightening and why the Indian health system must continually transition to be more productive and effective. Because real buying power of the Indian health system has not kept pace with the growing beneficiary population, the IHS has been streamlining, reducing staff, and restructuring to make the belt fit for many years.

As alternatives, the RIW proposes internal IHS reforms that will benefit front-line delivery of services to Indian people (see Section 8). However, the IHS cannot focus solely on belt-tightening because this approach will not close the gap in services or eliminate health status disparities. In fact, to eliminate health disparities Indian health care services must be expanded. All restructuring savings derived from restructuring in the IHS are best reinvested into additional health care services to American Indian and Alaska Native people—a productive, not counter-productive approach.

The HHS proposes to consolidate the functions listed below. Some of these functions will be consolidated immediately into the HHS by the end of FY 2003. Others will be consolidated in FY 2004 and FY 2005.



Figure 5.1, Consolidation Schedule Proposed by HHS

The RIW has identified the following concerns about consolidating IHS functions within HHS.

- The HHS consolidations will detract from the Government's responsibility to preserve Tribal sovereignty and will diminish services to the already underserved Indian population.
- The savings generated from the increased efficiencies predicted for One-HHS consolidation will not be reinvested in Indian health care.
- Characteristics unique to the Indian health system (Indian Preference, different budget and oversight committees in the Congress, Tribal shares, and how the system is based in hundreds of remote Indian communities very different in structure, function and location from most HHS agencies) may not blend well with other HHS agencies lacking these characteristics.
- Resources consolidated from the IHS will be diluted, lose focus, and jeopardize the specialized experience and support relied on by the front-line, community-based health care system.
- The One-HHS consolidation proposals have not been sufficiently detailed to adequately evaluate their merit or impact. Without the details and Tribal consultation, the RIW is unable to conclude the best course of action and are reluctant to endorse One-HHS proposals because of this uncertainty.

Alternatives

The main concern of RIW members is that consolidation of IHS functions within HHS will reduce resources for Indian health and make the disparities and funding gap worse, not better. In light of this counter-productive result, the RIW suggests that HHS reconsider its consolidation proposals and explore alternative ways to achieve the goals for efficiency, savings, and cohesion.

Although not endorsing all of the One-HHS proposals, the RIW offers alternatives that will lessen their concerns and serve to creatively and constructively participate in the One-HHS initiative while resisting a loss of resources to Indian health. The alternatives are consistent with the President's and the Secretary's goals, but achieve them in ways that are less disruptive to the Indian health system.

Consolidation of IHS Public Affairs and Legislative Affairs Staff Offices

Consolidating IHS public affairs and legislative affairs within HHS means that the HHS proposes to transfer 8 FTEs (\$779,000) from the IHS to the HHS. A primary objective for undertaking these consolidations is to ensure a more cohesive approach to legislation and public information among all the HHS agencies.

ADVANTAGES

- The staff will not physically relocate from the IHS headquarters office.
- Because they are physically remaining at IHS offices, they will maintain their immediate access to IHS leadership.
- The staff could be better connected to the HHS and raise the visibility of IHS issues and Indian Country's concerns.
- The staff could contribute to improved articulation of Indian health issues by HHS.

DISADVANTAGES

- The positions could lose their Indian Preference status.
- Tribal shares connected to the resources could be lost if they are not tracked.
- The IHS focus in staff assignments and work products could be diluted if the staff becomes absorbed in HHS work assignments and products.
- Responses to Indian Country could be delayed because it may take longer for clearance.

Tribal Leaders strongly oppose the transfer of the legislative affairs function. The IHS Legislative Affairs staff serves as a critical liaison to Congress, Tribal Governments, and Indian communities as well as between the IHS and the HHS administrations. To be effective, the staff must be closely connected with IHS administrative offices. Consolidating IHS Legislative Affairs has been discussed in many forums throughout Indian Country, and the response from Tribal Leaders is that this function should not be transferred from IHS. The HHS already closely supervises the IHS legislative staff for on-the-record activities. Why consolidate the IHS Legislative Affairs staff with other HHS legislative staffs when the IHS has separate congressional appropriations and, therefore, works with separate congressional oversight committees?

The RIW recommendations for Legislative and Public Affairs staffs are:

- 5.1 Maintain Legislative and Public Affairs staffs in IHS to ensure that HHS gets timely information from and well-informed analysis about Indian Country.
- 5.2 The IHS Legislation and Public Affairs staffs will coordinate closely with other HHS agencies in national emergencies and on cross-cutting issues to ensure cohesion of the HHS message.
- 5.3 Use performance contracts and inter-agency agreements to ensure IHS accountability to the Secretary for a cohesive approach to legislation and public information.

Consolidation of IHS Human Resources in HHS

The RIW was unable to evaluate the consolidation of the IHS human resources (HR) function within HHS because plans are still being formulated. The HHS-wide goal is to decrease the number of HR offices to four by the end of FY 2004. The RIW considered this goal, and looking through Indian Country lenses offers the following comments.

- Recruitment and retention of high-quality health care personnel throughout the Indian health care system is critical, especially in remote and isolated areas. Will the consolidations improve recruitment and retention and provide critical HR support functions in hundreds of health care locations in the Indian health system?
- A performance assessment of the HR within the IHS is appropriate. Realignment of selected HR functions could offer better support and higher levels of expertise.
- Consider whether outside sources could better perform some HR functions. As with all IHS functions, Tribes would have the first opportunity to contract for services formerly carried out by the IHS
- With newer technologies and software, opportunities exist to further automate HR recordkeeping, retrieval, and payroll.

Because IHS delivery systems are in rural and remote locations, it is not advantageous to consolidate HR with other HHS agencies.

- The IHS work force is composed of front-line health care providers and support staff, and is fundamentally different in character from the work force in most HHS agencies.
- Consolidating the HR function at a higher level in the HHS moves away from the front-lines of the Indian health system where the support is needed most.
- Human Resources functions and practices that work well in other HHS agencies, for example the scientific work force at the National Institute of Health and Centers for Disease Control and Prevention may not work well for a front-line health care delivery work force of 15,000 IHS employees in hundreds of sites in rural, isolated locations in Indian Country.
- The IHS operates under a unique law that applies Indian Preference in hiring and promotion practices. Most of the IHS work force (69 percent) are members of federally recognized Tribes. Their diverse cultures and traditions create a unique work force and work environment.
- A composite of HR staff from different HHS agencies can not ensure the specialized knowledge and skills needed to support the dispersed and remote locations of the IHS work force.

That Federal agencies become citizen-centered and results-oriented is easy to support. However, the proposed HR consolidations will not result in an agency more citizen-centered and more results-oriented. The recommendations for HR are:

- 5.4 Realign Human Resource (HR) support functions <u>within</u> IHS to take advantage of new technologies and enhance expertise available to all IHS sites in 35 States.
- 5.5 Avoid consolidating IHS' specialized experience and support for the dispersed community-based health care system with highly dissimilar agencies.
- 5.6 Implement operational improvements with the IHS to achieve performance goals envisioned by the Secretary.

Since the interim report was released, the RIW has explored internal reforms base on these recommendations for IHS human resources functions. A number of additional recommendations for improving administrative support, including human resources, are identified in Section 8.

Consolidation of Indian Health Facilities in HHS

The IHS is one of the few HHS agencies with a direct health care delivery mission; consequently, it has unique health-facility requirements. The IHS facilities' responsibilities, which American Indians and Alaska Natives depend on and which are part of the Federal Trust Responsibility, currently include safe drinking water and waste water disposal construction as well as the construction and maintenance of hospitals, clinics, health stations, staff quarters, and other ancillary buildings. These requirements deserve a specific focus connected to the Agency's unique mission.

Tribes, Congress, and the IHS have developed detailed processes for ascertaining facility needs, identifying priorities for health facilities construction, and determining methods for financing the design, construction, and maintenance of such facilities tailored to the unique challenges of the IHS operating environment. Consolidating Indian health facilities management into the HHS health facilities management process would unnecessarily complicate these processes.

The Secretary's concerns focus primarily on federal employee office buildings and facilities. The RIW has no objections to proposals regarding better coordination of federal office space. But, multi-agency facilities management offices are not advantageous for hundreds of IHS health delivery sites — many of which are in remote, rural locations.

- The consolidation with other HHS agencies will unnecessarily complicate the management of diverse and dissimilar facilities systems (i.e., the IHS facility construction priority-setting methodology, which is in response to congressional directives, may be compromised).
- Redirection of already inadequate facilities resources away from the growing backlog of construction and maintenance needs in Indian Country is counter-productive. (Approximately 30,000 Indian homes still lack either or both a safe water supply and adequate sewage disposal system. The IHS has identified a total backlog of 2,902 needed sanitation facilities construction projects costing \$1.6 billion to provide all American Indians and Alaska Natives with safe drinking water and adequate waste disposal facilities in their homes.)
- There is strong opposition in Indian Country to merging the facilities programs into the HHS.

The RIW recommendations regarding consolidating IHS facilities within HHS are:

- 5.7 Retain the IHS health care facilities and sanitation construction programs within the IHS to ensure its mission-critical focus is maintained.
- 5.8 Endorse HHS steps to better manage federal office space that does not impact front-line Indian health care facilities.
- 5.9 Use a memorandum of agreement to ensure full reporting and compliance of IHS facilities data with HHS standards.
- 5.10 The HHS should support increased funding to address aged and inadequate health facilities in Indian Country.

Since the interim report was released in June 2002, the RIW has explored options for internal reforms of Indian health facility and engineering programs. Additional recommendations to improve facility and engineering support are identified in Section 8.

The President's Management Agenda

Many of the reforms and improvements proposed by the RIW for the Indian health system match principles in the President's Management Agenda for FY 2002.

"The President's vision for government reform is guided by three principles. Government should be:

- Citizen-centered, not bureaucracy-centered;
- Results-oriented;
- Market-based, actively promoting rather than stifling innovation through competition."¹²

The President's Management Agenda principles provide a useful framework for describing corresponding RIW principles for reforming the Indian health care system.

The President's	Corresponding Principles
Management Agenda	for Reforming the
Principles	Indian Health Care System
Citizen-Centered	Patient-Centered
	Tribes and Indian people participate in IHS reforms. IHS responds to
	the patients (citizens) it serves.
Results-Oriented	Eliminate Disparities
	Disparities in Indian health, access to services, and health care
	resources are eliminated
Market-Based	Elective Outsourcing to Tribes
	Tribes electively contract or compact for an increasing share of IHS
	programs.

Citizen-Centered Linkages—Continuous Consultation and Participation

The President's vision for a citizen-centered government corresponds with the RIW vision that "patient care comes first" and that Tribes and Indian people (citizens and customers) participate directly in shaping reforms and policies that affect their health care system. The RIW, a constituent-dominated workgroup, itself demonstrates stakeholder involvement in planning the Indian health care system.

Citizen-Centered in the context of Indian health also means a continuous process of consultation. Consultation with Tribes is both the policy of the Federal Government and an effective means for American Indian and Alaska Native citizens to shape the health program to meet their needs. Tribes and Indian people must continue to participate in reviewing all plans and policies that affect the IHS, Tribal, or urban Indian health programs.

The Indian concept of health involves traditional Tribal principles, culture, and heritage—a characteristic not found in mainstream American medical care. While the Indian health system shares some features with mainstream American health care systems, a truly citizen-centered approach will accommodate and respect unique Indian traditions of wellness and healing.

The following citizen-centered principles¹³ have guided IHS reforms in recent years:

- Flexibility to serve diverse Indian communities, traditions, and cultures in differing creative ways.
- Decentralized decisions and shift of control to the local level where health care is delivered.
- Inclusion of Tribal and community participation.
- Shifting from overseeing front-line programs to supplying them with the services and technical assistance necessary to make them successful.

Results-Oriented Linkages—Eliminating Disparities

The RIW agrees with the President's Management Agenda focus on improving the performance of the Federal Government. His message:

"Government likes to begin things—to declare grand new programs and causes. But good beginnings are not the measure of success. What matters in the end is completion. Performance. Results. Not just making promises, but making good on promises."

Health status of American Indians and Alaska Natives is among the lowest of All Americans (see the statistics in Section 3). American Indians and Alaska Natives agree with the President about expecting results. They expect results that assure adequate health care services are available to them. They expect results that eliminate disparities in their health compared to other Americans.

The President's phrase "making good on promises" resonates powerfully with Indian people. Indian people view federal promises of health care services to Indians as a historic obligation of the U.S. Government based on treaties which ceded millions of acres of land in exchange for federal services including health care. Making good on these promises is only possible with a substantial expansion of resources to American Indians and Alaska Natives.

Market-Based Linkages—Outsourcing and Tribal Choice

The President's goal for a market-based government corresponds to outsourcing of IHS programs to Tribes. Since 1980, the IHS has undergone a transformation. An exclusively federal system was transformed to a system in 2002 with more than half its programs operated by Tribal governments. The transformation will continue. Transfers of programs, resources and FTE to Tribes will continue as Tribes elect to contract or compact. This is one of the reasons that additional FTE cuts for IHS are unwise.

Electing to contract or not contract are both equal expressions of Tribal self-determination. Although several large Tribes are in the process of contracting for additional portions of the IHS, other Tribes have expressed their intention to retain a federally-operated health care program. Therefore, not all IHS programs are expected to be outsourced to Tribes.

In addition to Tribal contracts and compacts, the IHS purchases supplemental health care services that are impractical for the IHS to deliver directly. Approximately 15-20 percent of the IHS budget goes to purchasing health care services and supplies from the private sector.

There also are market-based distinctions unique to American Indians and Alaska Natives. One distinction compared to outsourcing with competitive bids is that Federal laws provide a right to Tribes to electively operate IHS programs with resources no less than the IHS would have used.

Tribal Self-Determination Rights

Self-determination rights must be assured regardless of the ways the Indian health care system is restructured:

- 5.11 Ensure that IHS reforms accommodate and affirm Tribal rights to compact, contract, or retain IHS to operate health programs directly.
- 5.12 Track all realigned resources to ensure that resources available to the Tribes (known as Tribal shares) are not reduced as consequence of reforms.
- 5.13 Apply all savings resulting from restructuring to additional health care services for Indian people.

After Tribes assume operation of their health programs, most continue to seek some technical assistance and other professional support services from the IHS. Not all technical support must come from traditional sources such as the IHS Area Offices. Technical assistance could be supplied from regional centers, Tribes, Tribal organizations, or Indian-owned and other specialty firms.

Some Tribes are reluctant to contract or compact IHS programs because of the additional costs for overhead incurred with the operation of the programs. The Indian Self-Determination Act authorizes payment for costs that a Tribal contract/compact incurs in addition to the transferred program resources. Contract support costs are currently funded at 86 percent of the total need. This is one reason that contracting has slowed in recent years.

5.14 Fully fund contract support costs and other one-time costs of transition to remove the impediment for additional Tribal contracting and compacting.

Specialized Units for a Mixed Environment

Given the mixed environment of tribal, urban, and IHS operated health programs, the IHS has developed specialized organizational units supporting each type. These units are: 1) the Office of Tribal Self-Governance specializes in self-governance compacts; 2) the Office of Tribal Programs specializes in self-determination contracts and more generally as liaison with Tribes; 3) a mixture of IHS offices specialize in IHS direct care programs; and 4) the Urban Indian Health Program specializes in Urban Indian health projects.

To assure IHS support from headquarters adapts to the changing mix of programs in the field, the RIW recommends:

- 5.15 Assess the structure and capacity of the Office of Tribal Programs, headquarters direct support programs, and the IHS Urban Indian Health Program Office to complement the assessment already completed for the Office of Tribal Self-Governance.
- 5.16 Assure a balanced capability among these offices in accordance with the actual mix of selfdetermination contracts and compacts, IHS direct programs, and Urban Indian Health Programs.
- 5.17 Identify contingency plans to minimize service disruptions for any tribe potentially affected by retrocession of a contract or compact to the IHS.
- 5.18 Manage transfer of Tribal shares to ensure a smooth and orderly transition of programs, activities, functions, and services to all Tribes.





A VISION FOR HEALTH – ELIMINATE DISPARITIES AND SUSTAIN WELLBEING

Achieving health and well-being for American Indians and Alaska Natives first requires the elimination of heath disparities they have long experienced. This first part of the vision focuses on correcting problems and achieving parity for Indian health by filling in gaps in resources. The second part of the vision goes beyond Indian people having equivalent medical resources and treatment to sustaining well-being by returning to wellness centered Tribal cultural traditions and practices.

Eliminate Health Disparities

National comparisons of health status show that American Indians and Alaska Natives experience major health disparities compared to the health status of the nation as a whole. The RIW endorses the HHS national goals to reduce the rates of disease and death among American Indian and Alaska Native people to levels that equal rates for other Americans. The RIW urges the HHS and the IHS to aggressively pursue the national goals to eliminate health disparities. The special emphasis disparities that are particularly devastating to American Indians and Alaska Natives are:¹⁴

- Diabetes
- Unintentional injuries
- Suicide and violence
- Alcoholism and substance abuse
- Life Expectancy

Figure 6.1, Top Priorities

Common threads link the experience and causes of health disparities among all racial and ethnic minorities. A coordinated approach by the HHS to address the common root causes of disparities can be beneficial. However, there are more than 550 Tribes, each with a unique history, culture, and distinctive problems and circumstances. To be successful in eliminating disparities, programs must account for the distinctive circumstances of each Tribe and Indian community. The RIW urges HHS to include Tribal communities in designing programs to address their local needs.

Eliminating the health status disparities of American Indians and Alaska Natives begins with addressing the disparities in resources and health care services available to them. Theoretically, all members of federally recognized Tribes are eligible for federal health care services. However, what they get is better described as rationed health care. Life-threatening conditions get first priority, and if money is exhausted before the end of the fiscal year, as it often is, patients with lesser problems find their medical care postponed or simply not available. The gap in resources and services severely restricts health care services to American Indians and Alaska Natives and is one root cause of the failure to eliminate unacceptable rates of death and disease among Indians. Gaps in resources, access to, and use of health care services by Indian people is demonstrated with the following statistics:

- Only 22 percent of American Indians and Alaska Natives have employer-sponsored health insurance compared to 70 percent of all Americans (one reason is the extremely high unemployment rate on many Indian reservations). Forty-two percent of American Indians and Alaska Natives do not have health care insurance.
- The percentage of Indian elders with Medicare benefits (7 percent) is half the rate of other elderly Americans (13 percent).
- Despite having household incomes that are among the lowest, American Indians and Alaska Natives are enrolled in state Medicaid programs at a lower rate (34 percent) than other poor Americans (41 percent).
- The number of physicians per 100,000 population in Indian Country is 73.5 compared to the U.S. average of 229.3.
- The IHS can serve (incompletely) only 1.4 million of the 2.5 million American Indians and Alaska Natives living in the United States identified by the census data.
- The IHS expenditures for personal health care services was approximately \$1,775 per capita in 2001 compared to \$4,392 per capita for all Americans.
- A 1999 actuarial study found funding per IHS user was less than 60 percent of the cost of coverage in mainstream insurance plans such as the Federal Employee Health Benefit Plan.
- More than half of IHS and Tribal hospitals and clinics are more than 35 years old. The backlog to correct IHS and Tribal facilities deficiencies is estimated at \$1.6 billion.

Fill-In Resource Gaps

To effectively meet health care needs of Indian people, the RIW vision is to achieve parity in health care services and resources by 2007. To achieve this vision, the RIW recommends:

- 6.1 Double IHS funding on a per capita basis to bring resources for Indian health in line with those available to other Americans.
- 6.2 Ensure eligibility for Tribes and urban Indian health organizations to access and share in health care resources of other HHS agencies.
- 6.3 Double the number health care providers in the Indian health care system.
- 6.4 Eliminate shortages of doctors, dentists, pharmacists, nurses and other health care providers in Indian Country through better recruitment, training, and compensation.
- Replace, expand, and modernize aged inadequate hospitals and ambulatory clinics for a growing Indian population.
- 6.6 Invest in community infrastructure, especially for safe water supply and waste disposal—forms infrastructure that are virtually non-existent in remote areas of Indian Country.

The RIW supports aggressive action by the federal government to eliminate the unacceptable health disparities experienced by Indian people. However, the vision for sustained health and well-being of Indian people goes beyond having equivalent access to medical resources and treatment.

Sustained Well-Being Founded in Indian Cultural Traditions

Indian cultural beliefs and traditional Indian medicine arouse curiosity perhaps more than any other aspect of American Indian life. While beliefs, ceremonies, and rituals differ from Tribe to Tribe, many Tribes share an underlying belief that the natural or correct state of all things is harmony. Tribal beliefs, traditions, and customs handed down through many generations play a principal role in individual and collective Indian identity. American Indians and Alaska Natives strive to integrate closely within the family, clan, and Tribe and to live in harmony with the environment. This occurs simultaneously on physical, mental, and spiritual levels. For American Indians and Alaska Natives, wellness is a state of harmony and balance among mind, body, spirit, and the earth.

The traditional Tribal healing practices are of great value to Indian patients for restoring and sustaining health and well-being. Many Indian patients and their families consult with Tribal healers or practitioners. The IHS' Traditional Medicine Initiative emphasizes the alliance of traditional and western medical practices and the mutual support between community traditional healers and IHS health care providers. Through this initiative, the IHS seeks to foster formal relationships between local service delivery points and traditional healers so that cultural principles, beliefs, traditional healing practices are respected and affirmed by the IHS as an integral component of the healing process.

Wellness, Behavior, and Lifestyles

The role of traditional Tribal healers is more widely accepted now, especially as Tribal health care programs attempt to address serious health problems such as diabetes, alcoholism, substance abuse, and violence which are not easily remedied by modern medical practice. The role of traditional Tribal healing and other cultural beliefs and practices is especially important in health promotion because the concept of health for most Tribes is wellness-centered and enforced by social rules of behavior intended to help prevent illness and misfortune. Personal choices in diet, exercise, tobacco use, and alcohol consumption help determine health and well-being. Promoting healthy lifestyles means mobilizing American Indians and Alaska Native communities to return to wellness-centered traditions and practices.

The Link between Heritage and Health

Some of the most serious health problems afflicting Indian people have deep roots in poverty, cultural dislocation, and unhealthy lifestyles. This is where the vision for sustainable wellness comes in. Our vision for sustained well-being is founded on the re-enforcement of Tribal cultural principles and practices integrated with an adequately resourced medical system. Sustainability depends on combining the uniqueness of American Indians and Alaska Natives with the historic obligation of the U.S. Government to Tribes based on treaties and a big-picture approach to health and well-being shaped by Indian principles of family, clan, community, Tribe, and balanced living and harmony with the environment. The link between heritage and health is symbolized in the circle of life shown below.

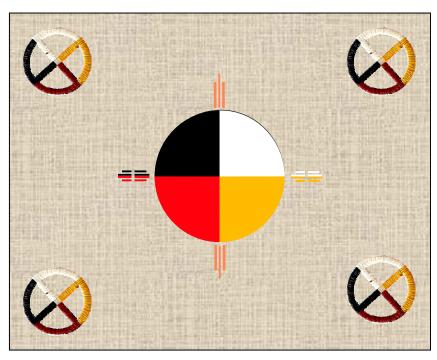


Figure 6.2, Circle of Life Symbol or Medicine Wheel¹⁵

Strategies to Sustain Health and Well-Being

The RIW vision for sustainable health and importance of heritage and spiritual practices accords with the President's Faith-Based and Community Initiative. The President's initiative welcomes the participation of faith-based and community-based organizations as valued and essential partners in assisting Americans in need. The Initiative identifies faith-based and community caregivers as those who are close to those in need and trusted by those who hurt. Tribal traditional healers fit this description.

By working in partnership with Tribes, Native communities, and the American Indian and Alaska Native people, the Indian health care system can help sustain health and well-being for American Indian and Alaska Native people by following strategies to:

- 6.7 Encourage and support traditional Tribal healers, cultural practices and principles;
- 6.8 Emphasize Indian beliefs, ceremonies, and traditional practices of harmony and health as grounding for individual identity and personal self-worth especially for young people;
- 6.9 Devote appropriate resources to wellness and prevention programs targeted to lifestyle including diet, exercise, and the avoidance of risky behaviors;
- 6.10 Recognize the whole person, extending to family, clan, Tribe, economic, and spiritual elements;
- 6.11 Reinforce Tribal values that encourage healthy choices and discourage harmful activities;
- 6.12 Support Tribal governance and infrastructure to provide a stable basis for community and individual development;
- 6.13 Build a viable economic base for employment in Indian communities, sustainable income, and means for self-support;
- Renew a healthy environment, in conjunction with other Federal agencies, by correcting environmental damage (toxic waste, dioxins in rivers, etc.) and preserving opportunities for hunting, fishing, and gathering from the land, rivers, and seas much as Indian people have done for thousands of years.

7



A LOOK 5 YEARS INTO THE FUTURE

Before examining reforms in the Indian health care system, it is helpful to look at trends in broader health care arena for potential impacts on the Indian health care system. This section provides a look at broad trends as a whole and examines specific trends in health care practice, costs and revenues, political issues in the health care arena, and the Indian population and demographics.

Trends in the Health Care Arena

The Indian health care system is not isolated and protected from change that is occurring in the American health care arena. Indian people are directly affected by trends in healthcare delivery systems, changing technologies, health economics, evolving patterns of disease, population demographics, and advancing medical practices. While the issues are complex and fast changing, several key trends are likely to emerge during the next five years.

TREND	IMPACT
Escalating technological change	Technologic innovation in health care is progressing rapidly and is a significant force raising costs. Whether or not there is sufficient resources for American Indians and Alaska Natives to have full access to these technologies is an open question. Already there are limits.
Shifting patterns of disease	In American Indian and Alaska Native (AI/AN) populations, chronic health problems and lifestyle affected diseases are clearly the most significant reality ahead. The health care literature abounds with examples of individual behavior increasing risks for disease and healthcare costs. Dietary excess leading to obesity results in much higher patient risks for heart disease, diabetes, osteoarthritis, pulmonary disease, and some other less common diseases. Smoking has clear impact on the rates and intensity of lung disease and cardiovascular disease. Addictions or abuse of chemicals contribute to deaths by accidents, family violence, and suicide. Of special concern in Native communities is alcohol abuse, and more recently, methamphetamine abuse, which are associated with Hepatitis B and C and other liver disease. Mental health diagnoses associated with long term chronic diseases and the devastating impact of chemical abuse and its consequent social impacts are on the rise in Indian Country.
Health promotion and disease prevention	It is increasingly evident that health promotion, disease prevention are effective ways to reduce future healthcare costs and improve quality of life for Indian people. The future survival of Native communities may

	depend on finding new approaches to sustaining health where technological interventions have little or no impact.
Rising expectations of Indian people	The Indian population has rising expectations of the Indian health care system. Indian people expect medical services, advanced technologies, and modern facilities that are available elsewhere in the U.S. to be readily available to them. Yet, per capita funding for Indian healthcare lags substantially behind expenditures for other Americans (see section 3). This reality forces rationing of access and services which conflicts with rising expectations among Indian patients. This often alienates patients from the system, making acceptance of health promotion messages regarding life style choices more difficult to achieve.
Re-vitalized Native practices and values	Re-vitalized Native community commitment to traditional practices and values concerning health could play a vital role in disease prevention and health promotion strategies. Awareness of balanced living and the role of traditional foods and life styles are re-emerging in Indian communities.
Comprehensive focus on underlying conditions	Parity in access to modern health care treatment and prevention services is essential for eliminating health disparities, but a narrow focus on resource parity alone is insufficient. A broader strategy that also includes partnerships with Federal, state, and tribal governments, business, educational systems, and law and order systems is necessary to change the underlying conditions of poverty, isolation, and education that condition behavior and lifestyle choices.
Tribal self-determination	Increasingly, Tribes operate and manage health care systems within native communities. This is one result of the self-determination movement for growth in tribal management capacity and infrastructure.

Health Conditions Trends

TREND	IMPACT
Increasing prevalence of chronic diseases (Diabetes, etc.)	Chronic diseases lead to longer clinic visits, more healthcare delivery outside the clinic, increased time hospitalized, increased need for services, and spiraling costs.
Increasing efforts to prevent disease	Expect higher costs in the short term, especially more competition for scarce resources between treatment and prevention. Expanding the prevention efforts depends on developing national, Area, and local expertise in prevention programs.
Periodic mini-epidemics (e.g., Hanta virus, etc.)	Anticipate expanding partnerships with States, Schools of Public Health, more public health infrastructure locally, regionally and nationally. Vaccine costs will rise.
Increasingly drug resistant organisms	Drug and pharmacy costs will continue to rise. Expect increased standardization using evidence based medicine and Information Technology (IT) in hands of clinicians.
"New" diseases (e.g. Hepatitis C) will emerge	Anticipate more emphasis on epidemiology, more interagency reliance, greater ongoing disease surveillance, more public health capacity. Spread of infectious diseases is now "global" given an airline interconnected world. New therapies will come with high costs.
Bio-terrorism preparedness	Preparations including stockpiled medications, personal protective equipment, decontamination, upgraded facility, increased training, and coordination among levels of governments will increase costs. Bioterrorism can detract attention and resources from other health care.

Quality of life	Expect greater emphasis on the functional wellbeing of individuals/families and increasingly difficult ethic/legal decisions. Partners outside the Indian health system are critical (e.g., HUD for transitional housing or assisted living housing).
Mental health	Anticipate expanding mental health services, growing costs, emphasis on traditional healing, and partnerships with law and order agencies.
Organ Transplants	Demand for organ transplants will increase and costs will increase.

Cost and Revenue Trends

TREND	IMPACT
Pharmaceuticals	Expect more standardization and limits on types of medications within particular classes, more public advertising by drug companies, and internet information in consumer hands. These trends create more demands by individuals for specific drugs. Expect newer agents "genetically tailored" to specific individual genetic make-up.
Expanding requests for other than clinical services	Expect growing community demands for school health programs, public safety support, wellness centers, new "incentive based" health promotion efforts, group home construction, and expanding demands on "care-giving" facilities.
Applications of the Human Genome Project	Anticipate growing numbers of treatments tailored to genetically determined health conditions. Related ethical questions will require education of providers, patients and community leaders.
Medicare reimbursements	Federal legislation could reduce Medicare benefits (or increase costs of Medicare coverage for some individuals) in order to provide broader prescription drug coverage.
Medicaid reimbursements	Under severe budgetary strains, States are setting benefits "caps" that reduce benefits and coverage and will result in less 3rd party reimbursement to I/T/Us and higher CHS costs.
Discretionary federal spending	Congress has signaled less spending for discretionary programs and more priority on existing entitlements and defense.
Outpatient service reimbursement	The reimbursement formula proposed by the CMS for January 1, 2004 eliminates the existing "OMB all inclusive rate" and may decrease revenue by 25% to 33%.
TANF	Third party coverage may decline (persons formerly on entitlements will be in low wage, part time jobs typically without health care benefits). Expect patients to migrate in and out of the Indian health system as their eligibility for Medicaid fluctuates on a monthly basis.
Private insurance	Three trends are clear: 1) fewer employers are offering health care insurance, 2) scope of benefits in employer sponsored insurance is increasingly more restricted, and 3) employees are picking up more of the costs (co-pays, deductibles, share of premiums). The numbers of the uninsured Americans is growing and covered benefits are shrinking. More Indian people will become increasing reliant on the IHS. The prospect for third party collections will level off or decline.
Wages for healthcare workers	Physician compensation will be flat but expect increases for nurses, technologists, technicians, pharmacists, dentists, many others.
Malpractice settlements	Anticipate litigation by patients to increase. Legislated caps on amounts of awards are proposed.
Emergency Medical Services	Expect fewer rural hospitals, greater utilization of Emergency Medical Services, more pre-hospital delivery services, greater technologic

	capacity in pre-hospital services, and increased use of Emergency Rooms for primary care particularly in urban areas.
Quality is imperative	Expect increasing attention to tracking and preventing medical errors (pharmacy equipment, IT equipment, needless technology, etc.).

Political Issues Trends

TREND	IMPACT
Costs and access are significant issues	Health care access and costs likely will be prominent campaign issue in Federal/State elections for 2002, 2004, 2006.
Consolidation of facilities/programs	Expect fewer rural hospitals with more restricted treatment capability, larger integrated healthcare networks, fewer individual physician practices, more ambulatory care and home care emphasis.
Rationing	Health insurance plans are reducing benefits at the same time that demands for higher cost technologies (laser versus eyeglasses, robotic surgery, painless dentistry, etc.) are rising.
Pace of change	Expect accelerated change in individual lives and healthcare programs. Increased demands for governments at all levels to be "nimble".
Increased expectations by others	IHS/Tribes can lead national and international efforts in reducing disparities and implementation of efficient health delivery models.
Enhanced local control	Expect loss of economies of scale in operations especially for support functions, increased emphasis on patient satisfaction, tribal capacity for traditional programs, strengthened tribal governments, communication among Tribes and between Tribes and Federal and other governmental entities (e.g., states with regards to public health jurisdictional and response issues), bidirectional technical support between IHS and Tribes, and evolving local interpretations of eligibility policies in response to a resource crunch.

Population Trends

TREND	IMPACT
Aging population	The Indian population is growing at 2.5% annually and more Indian people are living to stages in life when chronic health problems are numerous. Treatment of chronic problems, especially near the end of life, is extremely expensive. Expect costs of caring for an older population with chronic health problems to grow dramatically. The percentage of I/T/U resources used to care for older citizens will increase. Competition for scarce resources between chronic treatment and disease prevention will escalate.
Formally educated population	With more education and rising expectations for health care, Indian patients expect more services, particularly expensive technological services. They become better informed consumers able to choose alternatives to I/T/Us and expect more complete services.
Internet world	Both the Indian health system workforce and Indian patients are becoming more reliant on computers and the internet. Interactive tools at home/hospitals/clinics for patients will become widely available. Expectations for quality improvements using computer based approaches and electronic medical records has increased. Anticipate a higher percentage of spending on Information Technology. HIPAA implementation will drive up costs.

Patient satisfaction	Absolute expectation for services quality and patient satisfaction. Increasing use of centers of excellence, especially for more complex medical and technological services. More systems approach to services.
Staff retention	Provider attitudes have changed and now focus more on individual needs (e.g., salary, work schedules, etc.) and less on commitment to community. Anticipate shortages. Emphasize retaining professionals who excel and are loyal. Consider innovations such as opening Tribal/IHS facilities to full-time "private" doctors with their own offices.
Increasing urban migration	Census data shows an increase in the number of AI/AN individuals living in urban environments away from traditional tribal communities and governments. Access to culturally relevant health care is a rising concern for these populations and the extent of the Federal responsibility is in question.

Focus Areas for the Indian Health Care System during the next 5-7 Years

7.1 Make disease prevention the key objective.

An expanding beneficiary population, growing numbers of elders with chronic health problems, rising expectations for technological care, and mounting medical costs will increase pressure to devote scarce resources to treatment at the expense of prevention. But statistics suggest technologic solutions have limited utility in raising general health status, especially for chronic health problems related to lifestyle and behavior. A wiser approach is to invest a greater portion of the resources in health promotion and disease prevention. Because the competition between treatment and prevention for scarce resources will increase, it is crucial that System-wide policy redefine benefits and spending goals to assure sufficient investment in measures that will prove more beneficial to health in the long run.

7.2 Focus on behavior and lifestyle.

Avoiding risky behaviors and adopting healthier lifestyles would lead to significant improvement in health and avoidance of future treatment costs. Expand measures in both the clinical and community settings promoting healthy behavior and lifestyles. Since the majority of behavioral health programs are operated by Tribes, a joint analysis of performance and proven intervention measures is appropriate in designing these programs. Respect for traditional native health practices and values and their integration with behavioral health and wellness programs is a successful model proven in many Indian communities.

7.3 Strengthen public health capacity.

Public health capacity is an essential element of a comprehensive disease prevention strategy. Expand epidemiology (EPI) centers to detect and track emerging Indian health problems and to assess program effectiveness in countering Indian health problems. A new Indian Institute of Public Health may be a useful to strengthen public health knowledge in Indian Country and training for public health leaders. Coordinate patient education in clinical settings with a public health strategy of community outreach and education.

7.4 Invest in information technology.

Paradigms for clinical care, prevention, and public health are changing in response to rapid advances in information technologies and the internet. Modern medical practice depends heavily on information technology. While most disease prevention strategies are not highly technological themselves, information technology is vital to coordination of treatment, disease prevention, and

public health components necessary for maximum effectiveness. Enhance and integrate communications linkages among I/T/Us, tele-medicine capability, epidemiologic reporting and analysis, computerized patient records, productivity analysis, revenue and cost tracking, hand held technologies, and better information for providers and managers.

7.5 Workforce: re-examine the mix, strengthen recruitment and retention.

Re-examine the skills mix needed for an evolving health care system with a new mix of treatment, prevention, and public health components. Fund educational programs to develop necessary skills. Expand scholarship funding on a per capita basis. Enhance recruitment and focus on retaining valuable staff. Restructure personnel systems and support packages for appropriate reimbursement and training. Analyze and plan for contemporary market forces in the workforce. Legislation may be necessary to reform or gain exemptions from Federal personnel systems.

7.6 Adapt facilities for a broader approach to health.

Historically, IHS hospitals and ambulatory clinics were designed emphasizing patient treatment capacity. Space for community and public health activities was included but secondary. While modernizing and expanding patient treatment capacity in IHS health care facilities, adapt future facility plans to include more disease prevention and wellness capacity, chronic disease management and rehabilitation, assisted living, public health, community outreach and other innovations to address changing disease, population, and costs.

7.7 Adapt administrative support capacity to emerging trends.

Financial management, billing and collections, human resources functions, information technology, and supply and procurement systems must quickly adapt to changing trends. Realign the IHS' administrative support capacity and approach to human resources, cost accounting, timely billing, information systems to support decision making, and timely cost effective supply systems. Analyze staffing patterns and training and shift to "best in the business" models.

7.8 Reinforce linkages among I/T/Us.

In isolation, individual I/T/U, which are small by industry standards, are often inconsequential within larger market forces. In combination, the I/T/U system has much strength. Reinforce its strengths by solidifying structural relationships between I/T/Us, enhancing communications linkages, sharing analytic and technical assistance capacity. Identify new configurations that offer potential synergies from linking I/T/U capacities.

7.9 Assure that administrators are knowledgeable about healthcare.

Health care expertise is prerequisite for managers of successful health care systems. The literature indicates that the "best in the business" in healthcare expend significant resources continually training administrators on contemporary healthcare principles. Ensure contemporary business and health care training for administrative staff at all levels of the system.

7.10 Market as the "system of choice".

A case can be made that the Indian health system is the finest rural health care system in the Nation, but many Indian people, other health care networks with American Indian and Alaska Native beneficiaries, and millions of Americans know little about Indian health care and often rely on erroneous information. Inform, correct erroneous stereotypes, and market the Indian health system to be the "system of choice" for its patients and third party networks with Indian beneficiaries. Continuously measure patient satisfaction and make it a central focus in marketing the "system of choice."





INTERNAL RESTRUCTURING REFORMS

The June 2002 Interim RIW report addressed proposals to consolidate portions of the Indian health care system into HHS and how IHS reforms relate to the President's Management Agenda. Since June, the RIW has explored long range options for what the Indian health care system should look in 5-7 years.

Section 7 concludes with recommendations to guide the Indian health care system toward a new balance of treatment and rehabilitation services, disease prevention and wellness measures, and public health programs. Section 8 identifies internal reforms preparing the Indian health system to fit the new balance of health programs. The RIW considered four types of internal reforms:

8A: Administrative Support Reforms
8B: Facilities and Engineering Reforms
8C: System Infrastructure Investment
8D: Investment to Access Resources

8A: ADMINISTRATIVE SUPPORT REFORMS

IHS Administrative Workforce was Downsized

The IHS began serious internal reorganization in the mid-1990s that shifted resources and staff out of administrative roles and into front line health care roles. The workforce in IHS frontline service units has increased by 1,354 FTE (see charts in Section 4) since 1995. While specific FTE counts for the tribal service units are unavailable, reports indicate the tribal workforce also increased.

During this same period, the IHS administrative workforce was reduced by more than 2,000 FTE. The 2002 IHS administrative workforce is less than half of that of 1994. Reductions in the IHS administrative workforce were in response to several factors:

- Restructuring initiated by the 1995 Indian Health Design Team,
- transfer of IHS programs and resources to Tribes,
- administrative budget cuts directed by the Congress, and
- un-funded inflation and cost increases.

While restructuring, budget cuts, and inflation have prompted workforce reductions in all 12 Area Offices and headquarters, the extent of transfers to Tribes is not uniform among Areas. Downsizing to transfer resources to Tribes has been extensive in some Areas and less extensive in other Areas in which Tribes elected to retain the IHS to operate the health care system.

Request for Assessment and Restructuring Options

Following release of the Interim RIW report in June 2002, the RIW formally requested that IHS assess the strengths and weaknesses of administrative support for front line health programs. The RIW asked the IHS to recommend reforms to improve performance and prepare for changes expected during the next 5 years. The IHS assessed and prepared options to restructure the following administrative support categories:

- Human Resources and Personnel Support Functions
- Financial Management, Accounting, Budgeting Functions
- Contracting, Procurement, Acquisition Support Functions
- Records Management Functions
- Supply Management Functions
- Property Management Functions

The combined federal workforce in these administrative functions is approximately 650 FTE with annual costs estimated at approximately \$40 million. Data on the workforce and costs of these administrative categories for tribal health contracts and compacts are not available. Details of the RIW request are posted on the RIW website and may be downloaded at www.ihs.gov/NonMedicalPrograms/IHDT2/.

Performance and Support is Inconsistent

The IHS administrative workforce is less than half of pre-1995 levels. However, neither the administrative organizational structure nor its operational work practices have fully adapted to the reality of significantly less resources. Moreover, the administrative support system still must prepare for new and different support needs in the front line health programs. Consequently, a number of performance issues were cited for the RIW:

- Quality and level of support services to front line programs is inconsistent
- Delays in obtaining critical support services, .e.g., personnel actions, vacancy announcements, recruiting of needed health care professionals
- There are wide variations in staffing patterns among Areas which lead to inconsistent servicing ratios and uneven levels of support
- A single vacancy or absent employee can create bottlenecks and breakdowns in support services on which front line programs depend
- Collateral duties can dilute service quality
- Due to previous downsizing, fewer specialists with extensive experience are available
- Erosion of experience has forced reliance on junior personnel with limited experience
- Inconsistent standards and uneven application of national IHS policies, e.g., items approved in some Areas are denied in others
- Replicating management staffing patterns across multiple Areas is less cost-efficient
- Downsizing has made compliance with some Federal regulations more difficult
- Coordination among similar staff across Areas is insufficient or missing

Administrative Realignment Options

The RIW considered four ways of realigning IHS administrative functions to address declining resources, inconsistent performance stemming from fragmented operations, and evolving needs of frontline health care programs:

- Central Shared Services
- Regional Shared Services
- Share Services With Another Agency
- Purchase Services Contractually

Feasibility, estimated efficiencies, advantages, disadvantages and transition issues for each realignment option were examined. Most significantly, the RIW wanted to see if the realignment would produce any savings that could be redirected to expand health care services to Indian people. Specifically, the RIW set the following objective:

"An objective of the restructuring options is to reduce by 10-20% the total resources devoted to the administrative functions at headquarters, Areas, and Service Units, with all savings being redirected to health care delivery."

Complete details and realignment options are posted on the RIW website and may be downloaded from www.ihs.gov/NonMedicalPrograms/IHDT2/.

Regional Support Model Offers the Most Benefits

After weighing the advantages and disadvantages of the realignment options, a consensus gradually emerged for the following conclusions and recommendations:

8.1 Realignment will improve consistency, quality, and timeliness of administrative support to front line health programs.

Timeliness and quality of administrative support services will erode further unless IHS's organizational structure and operational work processes are transformed to address declining resources and changing needs. The changes are not necessary because of the President's Management Agenda or the "One-HHS" restructuring. The changes are needed to improve performance and to adapt to changes anticipated during the next 5 years.

8.2 A regional configuration offers the best combination of potential savings, improved support service, and lower transition costs.

A regional approach will increase efficiency, lower costs in the long run, attract higher skilled staff and expand expertise, provide greater depth, backup, and coverage in a smaller workforce, and provide more consistent application of standards and policy.

8.3 No IHS Area Office will close.

Area offices will continue providing technical assistance to front line health care programs. Tribes value Area Offices for access to IHS leaders, for familiar working relationships, and for expertise on local health issues. While the mix of components at each Area office may vary overtime, all front line health care programs will have access to the full array of administrative support services from the combination of Area Office and regional center.

8.4 It is not feasible or appropriate to regionalize all administrative functions.

Realigning administrative functions which require specialized local expertise and are based on close working relationships with customers would be counter productive. For instance, specialized working relationships needed to administer tribal self-determination contracts and compacts, employee relations, and budgeting are examples of functions to retain at Area Offices in most cases. Commonplace administrative functions (e.g., commercial type functions) which are best carried out in an efficient standardized fashion are good candidates for regionalization. Examples of functions to regionalize include processing of personnel actions and paperwork, human resources record keeping and retrieval, reporting and statistics, travel, payroll, claims processing, commercial acquisition functions, auditing, and accounting.

8.5 Combined savings of approximately 100-150 FTE and approximately \$5 million – \$7.5 million can be realized by realigning some administrative functions into regional teams.

The regional approach offers a balance of potential savings, consistency and quality of services while also limiting the number staff that must be relocated. Estimates of savings are being independently examined by the technical staff from the IHS Business Plan Workgroup.

8.6 Direct all savings from regionalization (estimated at 100-150 FTE and \$5-\$7.5 million) into health care services for Indian people.

One way to visualize the savings is to imagine that 150 administrative staff will be transformed into 150 nurses. While organizational change is universally acknowledged as difficult, the IHS and Indian country must determine whether this trade-off is beneficial and worthwhile.

8.7 Preserve and track every Tribe's "shares" of realigned FTE and resources.

The IHS must track tribal shares regardless of the form the organizational structure takes. In practical terms, this means a tribe's shares will remain preserved and unchanged whether an administrative function is supplied by an Area Office or from a regional center. The resources are linked with each tribe and available for transfer to the tribe when it elects to contract or compact with the IHS.

8.8 Honor existing commitments that obligate Area Offices or headquarters to provide support services in a fashion specified in a binding agreement.

Any agreements that bind IHS to prior arrangements for providing administrative support will remain in effect through the duration of the agreement unless renegotiated.

Phased Transition Contingent on Results

All transitions are difficult. Transition of IHS administrative support functions to a regional model will involve technical difficulties and cost several million dollars which will delay realization of savings for several years. The RIW proposes a transition plan to avoid abrupt and disruptive conversions. The plan will minimize transition costs by lessening immediate need to relocate IHS staff and may realize earlier savings to enhance patient care services.

8.9 Regionalize appropriate administrative functions in a phased incremental fashion designed to avoid disruptions, develop and test new operational methods, and minimize conversion costs and employee relocations.

Organizational transitions are easier if voluntary. The odds of a successful transition are enhanced if consideration is given to testing solutions that work in real world conditions.

8.10 Phase-One: In-Place Regionalization: Begin regionalizing administrative organizational structures, span of support, and operational practices to create regional support teams "In-Place."

The first phase involves consolidation of delegations of authority, supervisory channels, and work processes into regional teams spanning 2-4 Areas. Area Office staff would not be relocated immediately. Some workforce reductions thru reassignments, retirement, early outs may be appropriate. Work would be reengineered with communication linkages, data bases, email, electronic file management, and internet customer support portals. With the right tools and training, it will not matter to the customer in a front line program whether help is located across the hall or across the U.S. This approach avoids abrupt disruptions, minimizes transition costs, tests regional support tools, and provides built-in incentive for IHS staff to make the transition successful to avoid geographic relocation. Realignment to in-place regional support teams could achieve performance and savings goals without requiring most staff to geographically relocate. However, if improvements are not realized, move to Phase-Two.

8.11 Phase-Two: Regionalization With Geographic Co-Location of Staff: After a period to develop and implement new regional support teams, and if initial results from phase-one are unsatisfactory, relocate appropriate administrative staff into 3 regional support centers.

The RIW suggests 3 regional centers as a working goal. Selection of appropriate locations for regional support centers will depend on balancing a number of criteria such as costs, transportation and travel linkages, proximity to a large and skilled American Indian and Alaska Native workforce, proximity to educational institutions, and balancing regional access and customer workload. An analysis of these factors is premature at this time, but must be undertaken before advancing to Phase-Two regionalization.

The following graphical depictions may assist visualizing RIW ideas for transitioning the existing fragmented administrative configuration into regional support teams.

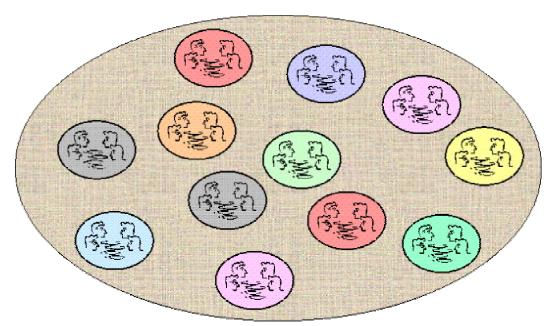


Figure 8.1, **Existing Configuration**

Area Offices are separate and unlinked with little sharing and backup capacity.

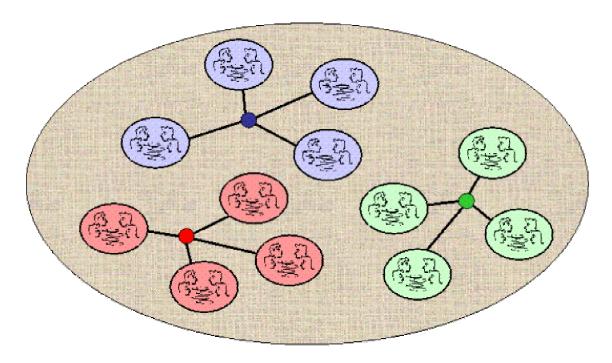


Figure 8.2, Phase 1: "In-Place" Regional Support Teams

Regional teams are configured "in-place" without significant staff relocation. Team responsibilities are extended to support I/T/Us in 3-4 Areas. Linkage, coordination, and backup capacity are provided.

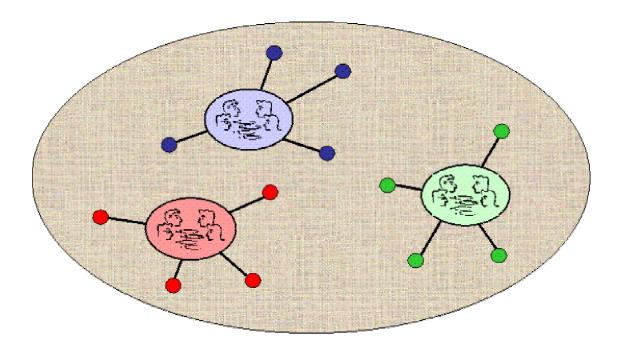


Figure 8.3, Phase 2: Full Regionalization

In this model, regional teams are relocated together in 3 locations. Teams support I/T/Us in 3-4 Areas. Coordination, cross-training, and efficiencies are easier to obtain than with in-place teams.

8B: FACILITIES AND ENGINEERING REFORMS

Tribal leaders are concerned with both the long period to become eligible for a new health care facility and with the lengthy period for planning, design, and construction phases, once approved for a facility. The RIW formally requested that IHS assess the strengths and weaknesses of IHS facilities and engineering programs, recommend reforms to improve performance, and prepare for changes expected during the next 5 years. The IHS prepared options for the following categories:

- Patient load benchmarks for planning facilities and programs
- Facility Construction Priority System Methodology
- Potential consolidation of engineering services sites
- Reforms to streamline facility planning, design, and construction

Patient Load Benchmarks

The IHS uses two sophisticated methodologies to plan for health care delivery programs. In the first step, the Resource Requirements Methodology (RRM) forecasts patient workloads and identifies appropriate services and staffing patterns. In the second step, the Health Systems Planning (HSP) methodology determines the appropriate facility space and design specifications. Both systems consider professional standards of care and industry standard thresholds and benchmarks to ensure safe high quality services and cost effectiveness. A detailed assessment of the planning benchmarks can be downloaded from the RIW webpage at www.ihs.gov/NonMedicalPrograms/IHDT2/.

- 8.12 The RIW endorses IHS patient workload benchmarks for determining the size and type of facility based on patient workload and population.
 - The IHS planning methodologies appear to be based on a sound rational basis and data. For instance, an older hospital is considered for replacement only if the forecast average daily patient load (ADPL) exceeds 15 except in cases of extreme isolation and distance to alternative hospitals. In-patient loads of less than 15 ADPL are neither cost effective nor sound for assuring high quality patient care and safety.
- 8.13 When applying patient workload benchmarks to plan new or replacement facilities, consider community input as an additional factor and maintain some planning flexibility consistent with assuring a safe and cost effective facility.
 - RIW members point out that no single standard is sufficient to address the wide array of circumstances found in Indian country. Some flexibility is necessary for unique circumstances.

Facility Construction Priority System

The IHS facility construction priority system ranks health care facility construction projects based on age, capacity, condition, and isolation. The ranking system was created in response to Congressional wishes to assure that federal funding for IHS health care facilities addressed the greatest needs in Indian Country. Congress's intent was to avoid a political "pork-barrel" process that arbitrarily favored jurisdictions served by powerful members of Congress.

There are currently 24 projects on the priority system list that was created in 1992. There are many more potential projects not on the list. IHS estimates that construction projects now on the list will require \$900 million to complete. If annual facility construction funding averages \$90 million, it will take 10 years to clear the list. Given the age and poor condition of many health care facilities in Indian Country, the long delays to obtain funding are extremely frustrating to tribal leaders. Moreover, because projects added to the list in 1992 have not cleared, a decade of cumulative growth in population, workload, and continuing facility deterioration is not reflected in the existing priority list. At the current pace of funding, another decade of cumulative growth in demand and deterioration of capacity will be ignored before the priorities are revised.

8.14 The RIW endorses the Facilities Appropriation Advisory Board (FAAB—a joint IHS/Tribal facilities construction workgroup) process for modifying the IHS facility construction priority system including necessary tribal consultation before adopting revisions to the priority system.

The FAAB workgroup has considered a range of issues, including provisions for small populations and proposes these modifications to the facilities priority system criteria:

40% -- Facility deficiency (capacity, age, condition)

15% -- Isolation and documented barriers

20% -- Health Indicators

10% -- Innovation

15% -- Type of Facility (station, ambulatory center, hospital, medical center)

8.15 The most significant obstacle in addressing facility deficiencies is the lack of resources for construction.

Revising the priority system itself will not provide Tribes with significant additional resources for facility construction, but may better reflect cumulative change in conditions since 1992.

Potential Realignment of Engineering Services

The RIW considered four ways of realigning IHS engineering services functions:

- Consolidate engineering services offices now in Dallas and Seattle
- Disperse Dallas and Seattle functions to Area Offices and headquarters
- Purchase engineering services commercially
- Assume leadership responsibilities for some HHS facilities functions

Complete details of assessments and realignment options are posted on the RIW website and may be downloaded from www.ihs.gov/NonMedicalPrograms/IHDT2/.

8.16 The RIW does not recommend further consolidation or dispersal at this time of engineering functions now located in Dallas and Seattle.

Members of the RIW request further study of this issue in view of the HHS proposal to consolidate HHS facilities programs in FY 2004. See Section 5 for concerns about consolidating IHS facilities and engineering programs within HHS. Furthermore, structural change may be unnecessary if measures to streamline work are successful.

8.17 The RIW recommends further study of whether Indian Country will benefit if the IHS assumes a "leadership" role for some HHS facility and engineering functions.

This concept has possible benefits from supporting the Secretary's "One-HHS" initiative, taking advantage of IHS facilities and engineering program strengths, and possible synergies and resources from working with other agencies. However, support for this concept is contingent on:

- -- verifying that a new HHS role and linkage will not degrade IHS facility and engineering services, and
- -- that other HHS agencies reimburse the IHS for the costs of services and support.

Streamline Planning, Design, and Construction

Construction of a new or replacement health care facility begins with identification of need (workload and population forecasts) and culminates with the completion of a new building. The process in between these two points is long, involved, and includes numerous players from the service unit, Tribes, Area Office, several Headquarters offices, and engineering services offices. This process involves a lot of people. It is good to involve all stakeholders, but this takes a lot of time. IHS identified four major items that slow down the planning and design process:

- Involvement of numerous stakeholders in planning and design
- Extensive waits for Congress to appropriate construction funding
- Insufficient planning expertise in the Area Offices (facility planning is infrequently undertaken in Areas and getting staff up to speed takes time)
- Local IHS staff and Tribes often have unrealistic expectations for the types of services that can be provided cost effectively and safely.
- 8.18 The RIW endorses no-cost measures to streamline planning, design, and construction as proposed by the IHS.

Complete details and proposals to streamline planning and design work are posted on the RIW website and may be downloaded at www.ihs.gov/nonmedicalprograms/IHDT2. While initiatives that increase costs require further study and justification, examples of no-cost streamlining measures the RIW endorses are:

- Centralize planning and for consistency and responsiveness
- Complete planning documents prior to appropriations
- Minimize phased funding except on very large projects
- Timely review of design schematics
- Minimize re-bid delays by combining bid solicitation with preference to Indian bids
- Increase review thresholds to \$5 million and random sample contracts for review
- Centralize and contract for equipment purchasing and installation
- Base warrants on qualifications, not numerical limits by office
- Float engineering and contracting resources to field locations based on workload

8C: SYSTEM INFRASTRUCTURE INVESTMENT

A New IHS Business Plan

The Business Plan Workgroup is examining a variety of emerging business practices to improve performance, economize on costs, maximize collections and render support services to front-line health providers. The Business Plan Workgroup, 25 individuals who are Tribal Leaders, IHS officials, and

representatives of urban Indian health programs and national Indian health organizations, is charged to recommend a business plan for enhancing the level of patient care for American Indian and Alaska Native people over the next 5 years. The Business Plan Workgroup is updating and refining the IHS Business Plan and will submit the draft plan to American Indians and Alaska Natives to seek their input in the plan. In updating and refining the IHS Business Plan, the Business Plan Workgroup will explore how the Indian health care system can improve its business practices to address current and emerging issues over the next five years.

8.19 Adopt and implement a new IHS business Plan when delivered by the Business Plan Workgroup.

Enhanced Bio-terrorism Surveillance and Response

The Indian health care system must detect emerging health problems earlier so that resources and programs can be targeted effectively. Like all Americans, American Indians and Alaska Natives have new concerns about the potentially devastating effects of bio-terrorism and accelerating concerns about communicable diseases that could re-emerge with increasing resistance to antibiotics. American Indian and Alaska Native history includes devastation of whole Tribal populations by communicable diseases. Indian Country is understandably concerned about bio-terrorism and the re-emergence of communicable diseases. The RIW supports a coordinated approach to epidemiological surveillance and response for Indian Country in the following areas:

- opportunities to participate in bio-terrorism programs and resources;
- participation in the Health Alert Network newly established as part of homeland security measures;
- ways to coordinate with organizations such as VA, CDC and State health departments;
- concentrated tracking and attention on health issues and diseases of the American Indian and Alaska Native populations; and
- disease surveillance and response tailored to the unique environmental and cultural factors of Tribal communities.
- 8.20 Develop a coordinated approach to bio-terrorism that participates with and shares bio-terrorism preparedness resources from other Federal and State agencies.

Investment in information technology

The RIW reviewed a five-year plan to invest in information technology (IT) and to connect all local IHS, Tribal, and urban Indian health sites through an Indian Health Network. More importantly, the RIW envisions communications technology linking all Indian hospitals and health centers throughout the United States. A modernized nationwide network offers a way to integrate operations, and to access support services and assistance, and share capacities from any site in the United States. Such capacity is essential to full implementation of the regional support team model presented earlier. The historic constraints on progress resulting from geographic remoteness and the inefficiencies of dispersed small-scale operations would diminish as sites work together to increase buying power and lower costs. The emerging telemedicine and distance learning technologies are ideal for health care sites located in remote areas that often experience harsh weather conditions. The possibility of leveraging marketplace clout through the collaboration of hundreds of sites while maintaining local flexibility and independence is worth further exploration.

The RIW reviewed and supports the Information Technology Vision and Actions for 2007 and considers it a companion document to this report.

- 8.21 Triple investment in information and communications technology over the next five years.
- 8.22 Create an interconnected Indian Health Network for hundreds of widely dispersed health care sites to more effectively collaborate and pool information, expertise, and resources.
- 8.23 Standardize data systems and protocols to assure all locations work together using common standards for communication and interoperability.
- 8.24 Specify hardware and software standards to assure all sites maintain compatibility while preserving flexibility to select differing hardware.
- 8.25 Utilize compatible information systems developed in the larger, better funded federal health care systems such as Department of Defense and Department of Veterans Affairs.
- 8.26 Develop a national data warehouse where consolidated data is retrievable from all sites throughout the Indian Health Network.

Environmental Safeguards Technical Assistance

The RIW has identified a need for additional technical support from IHS, the Environmental Protection Agency (EPA) and others for environmental health, particularly with respect to safeguarding Indian communities against nuclear and hazardous waste, assuring water quality, and related functions.

The IHS environmental health programs works with partners to provide training, monitor environmental conditions, investigate problems, develop sound public health policies, implement prevention measures, and promote safe and healthy environments for all Indian people. But environmental health issues are sometimes confused with environmental protection issues. The IHS has proposed a modest expansion of technical assistance capacity to address environmental hazards while maintaining its "advocacy" posture and leaving environmental regulation and verification roles to EPA and other agencies created for that purpose. Complete details of assessments and proposals for providing additional technical assistance are posted on the RIW website and may be downloaded from www.ihs.gov/NonMedicalPrograms/IHDT2/.

8.27 Expand technical assistance capability within the IHS environmental health program by creating Environmental Safeguards Technical Assistance Teams.

This modest expansion creates mobile teams formed for short-term assignments and composed of staff from existing IHS and tribal programs. The teams would assemble the necessary expertise to provide TA on air, water, soil contamination and remediation. Additional costs are limited to per diem, travel, and backup support where necessary.

User Definition

Because of limited capacity and varying availability of services, Indian people often visit multiple IHS, Tribal, and Urban Indian facilities to obtain needed health care. This pattern of use creates a financial burden at every facility visited by the patient. However, for funding purposes, the IHS currently assigns each person to the health care facility nearest their place of residence. This way of defining a user does not account for costs in other facilities visited by the patient. Although the most fundamental problem is severe under funding for the Indian health system as a whole, the RIW has concluded that this issue further worsens financial burdens in some IHS and tribal facilities.

8.28 Reconsider the user count definition employed in IHS resource allocation formulas to account for costs in all facilities used by the patient.

RIW members remained concerned about financial consequences of the IHS user definition. IHS should appoint a joint IHS/tribal workgroup to fully explore legal, financial, and technical ramifications of revising the user count definition for resource allocation formula.

8D: INVESTMENT TO ACCESS ADDITIONAL RESOURCES

Resources for Indian health care likely will be insufficient during the next 5 years. Additional resources are needed to cope with growing Indian health care needs, assure access to health care services on a par with other Americans, and eliminate Indian health problems.

Given the magnitude of resource needs, it is frustrating to Tribal leaders that other Federal agencies often see Indian health issues solely as an "IHS responsibility." Moreover, when resources from other agencies are available to Tribes and Urban Indian programs, resources are often not accessed because of poor information or breakdowns in the application process. For instance, a recent study identified 45 grants and assistance programs within HHS for which Tribes are eligible but are not accessing.

The RIW has identified a 2-part strategy for improving access to resources from other federal agencies. The first part focuses on expanding cross-agency linkages, removing eligibility barriers, and gaining commitments from other HHS agencies for additional resources for Indian health.

- 8.29 The IHS executive leadership will work to persuade the Secretary to make Indian Country a very high priority for the Presidential priority of eliminating health disparities.
- 8.30 The IHS will work with sister HHS agencies to identify their role and responsibilities to eliminate health disparities of Indian people and seek concrete commitments to fund programs for eliminating those disparities.
- 8.31 Charge the Interdepartmental Council for Native American Affairs with identifying former IHS and tribal employees in DHHS regional offices to be included in tribal issues workgroups and to advocate for Indian issues.
- 8.32 Charge the Interdepartmental Council for Native American Affairs with drafting and recommending to the Secretary an element to include in all HHS agency director's annual performance contracts, specifying target resource amounts to be dedicated for use in Indian country.
- 8.33 Assign senior IHS employees to other HHS agencies to pursue policy support and funding for Indian needs.
- 8.34 Pursue legislation to remove barriers (Title XIX) that prevent Tribes from contracting directly.

These ideas have few costs, except for 8.32 which will include salaries and benefits for up to 5 IHS FTE assigned to other agencies.

The second part of the strategy focuses on investing in technical assistance capacity so Tribes, IHS, and Urban Indian health programs can realize all resources for which they are eligible. Untimely information about available resources and insufficient capacity to successfully apply is limiting funds that would otherwise flow to Indian Country. The RIW heard from several tribal programs and urban projects about programs built on successfully accessing multiple funding sources. Their message: "invest in expertise to write proposals and apply successfully."

8.35 Establish a Center for Tribal Access to Resources chartered to assist Tribes to realize all resources for which they are eligible.

The Center for Tribal Access to Resources would be funded by \$1.5 million seed money from IHS. Establish the center through a tribal organization or Indian organization rather than as part of the IHS. As the Center develops its network and capacities, it can obtain additional funding through foundations and grants from organizations that support Native American issues. The center would assist Tribes, IHS, and Urban Indian Programs access and realize resources in three ways:

Information Clearing House Role

- Provide an internet portal for "one-stop shopping" of public funding available to Tribes
- Maintain an up-to-date, on-line data base of solicitations (RFP/RFP/PA) geared to tribal access
- Distribute information about new funding opportunities to Indian Country through newsletters, email, fax, and the internet
- Assemble from differing agencies all materials, forms, applications for accessibility in one place
- Provide tip sheets, kits, model applications, and success stories from which Tribes can further develop local expertise in applying for resources
- Identify useful "collaborators/partners" (Indian organizations, universities, etc.) with which Tribes can partner for technical expertise often required in solicitations

Technical Assistance Role

- Maintain a "Help Desk" that Tribes may call
- Provide technical assistance on applications and in preparing proposals
- Offer elective "quality assurance" review of tribal applications and provide feedback and pointers for improvements
- Provide workshops and seminars on all facets of identifying, accessing, and getting funding

Outreach / Partnership Role

- Match Tribes with new resource opportunities based on their unique characteristics and needs
- Actively outreach to Tribes, Indian Organizations, Urban Projects to promote ways to take advantage of emerging resource opportunities
- Actively outreach to federal agencies and other sources to advocate for tribal eligibility and inclusion in funding distributions
- Offer "Best Practices" workshops designed to bring together successful programs, "network", and share experiences and best practices
- Identify successful tribal program "mentors" that can assist other Tribes

RIW Report Conclusion

The RIW provides this report to the IHS with an understanding that its recommendations will be made available for consultation with Indian Country. The next big step is for the IHS to consult with tribes, Indian health organizations, and Indian people and consider all views and suggestions before adopting any recommendations that affect the Indian health care system.

The RIW considered complex issues and difficult challenges. We have worked hard to fulfill our charge to "recommend design changes to IHS that will advance the health of all Indian people by considering representative views from throughout Indian Country." Given the time available to us, we believe we have come up with a realistic guide for change. Even though our part is nearly done, the process is far from over. Consultation undoubtedly will produce even more ideas for consideration and much work to develop detailed transition plans remains.

APPENDIX COMMENT ON THE INTERIM REPORT

This appendix summarizes comment and feedback on the June 2002 Interim RIW Report.

Several comments endorsed a temporary waiver for the IHS from the "One-HHS" initiative. The final report recommendation 2.10 states "The HHS Secretary must exempt the IHS from full-time equivalent (FTE) and budget reductions since the Agency is under funded and had recently restructured in order to shift administrative resources to direct services in communities where Indian people are served."

Numerous comments called for the federal government to honor the government-to-government relationship by allowing Tribes sufficient time to review and comment on HHS recommendations. RIW members concur. The final report maintains references to the government-to-government relationship as one of the eight "core" principles to guide restructuring plans. The RIW members support expansion of the time frames allowed for review, response, input, and participation in the consultative process.

Several comments "call for the DHHS to conduct meaningful consultations with Indian Tribes before taking actions that would affect Indian health care." RIW members concur. Members note that the RIW is not the sole vehicle for tribal consultations. The RIW is part of a process in which tribal leaders and stakeholders are engaged in shaping plans and policies that affect Indian Country. The RIW provides input from Indian Country in the form of recommendations to the Director, IHS. Ultimately, the federal government, including the IHS and HHS, has a responsibility consult directly with Tribes before taking actions that affect Indian health care programs.

Most comments opposed consolidation of IHS functions within HHS. Some opposed consolidation of the IHS Office of Congressional and Legislative Affairs because of negative impacts on the government-to-government relationship with Tribes. Others recognized potential benefits from closer coordination with HHS for financial management and data systems. The final report maintains recommendations opposing consolidation with HHS that would decrease IHS resources, which are already under funded. Section 5, "One-HHS Proposals & the President's Management Initiative" in the final report offers a number of alternative ways to help achieve HHS goals for greater efficiency without loss of resources for Indian health.

Several comments stated that HHS consolidations "would undermine Indian self-determination ..." One stated "Renewed concern about pre-emptive steps taken by HHS had decreased consultation in the IHS budget formulation process that threatened appropriations for Indian health." RIW members concur. The final report references "Core Principles in Indian Health" to maintain Indian Self-Determination and Tribal consultation.

Several comments referenced an obligation of the federal government to "respect the rights granted by treaties." One noted that "federal trust responsibility to American Indians would be diminished" if HHS consolidates portions of IHS into HHS. RIW members concur. The final report contains references in Section 2, "Core Principles in Indian Health" to maintain Federal Trust Responsibility and Tribal Sovereignty.

One comment "opposed the process completely." While most RIW members oppose "One-HHS" consolidation proposals and call for HHS to consult directly with Tribes, most RIW members also feel that Indian people must take advantage of the opportunity afforded by the RIW. This view is expressed in the final report as "The internal and external forces putting pressure on the Indian health care system will not go away if we ignore them. This is an opportunity for Indian country to guide change. If we let this opportunity pass, we run a risk that others will do it for us – maybe in ways that are not in our best interest."

One comment "supports adoption and implementation of the RIW recommendations." The final report maintains most recommendations of the interim report and adds new options and detail for internal restructuring to prepare the system for changes anticipated during the next 5-7 years.

Several comments advocate for a stronger health emphasis in the RIW report especially for disease prevention and health promotion. Important work conducted by the RIW since the interim report examined the impact of health care trends on the Indian health care system. This work resulted in a new Section 7, "A Look 5-Years into the Future," which extensively explores health implications and options. Section 7 of the final report includes new reforms to address Indian health disparities including a new balance among treatment and rehabilitation, disease prevention, and public health programs. Recommendations 7.1 "Prevention is Key," 7.2 "Focus on Behavior and Lifestyle," and 7.3 "Strengthen Public Health Capacity" are a direct result of RIW members concern for a greater focus on health in its options for the future.

At least one comment mentioned that FTE charts did not include tribal employees and therefore would understate restructuring in recent years. The final report acknowledges that data for the tribal health care workforce is unavailable and that the FTE trends in Figure 4.1, 4.2, and 4.3 are understated. Note that the addition of tribal data, if available, would likely augment the rising trend already evident for the front-line workforce.

Several comments wanted "more specific" restructuring plans. The final report includes new recommendations for internal restructuring in sections 7 and 8. Subsequent analysis of technical factors is necessary.

Several comments cited inadequate resources, e.g. "the government needs to properly fund the agency before it can expect big results." One requested that "FDI per capita" information be included in the report. Another stated "there is far too little health care resources for increasing populations with worsening health statistics." Another stated "DHHS restructuring fails to take into account the historic under funding of the IHS." Another stated "firm opposition to any effort to offset third party collections." In section 3, "Troubling Disparities-Unequal Health Care," data from the Federal Disparity Index is cited along with other benchmarks to document inadequate funding for Indian health. The following statement was added in the final report: "On a per capita basis, IHS funding translates to 55 percent of the cost of mainstream health insurance plans."

Recommendation 6.1, in subsection "Filling in Resource Gaps" states: "Double IHS funding on a per capita basis to bring resources for Indian health in line with those available to other Americans."

A number of comments included statements such as "we support the RIW recommendations and would like to have Finance, Contracts, and Human Resources retained at the Area." The final report recommendations include realignments of administrative functions to improve performance. The report defers location decisions to allow necessary technical analysis of cost, access, balance of work, etc., and after appropriate consultation with Tribes. As a transition step, formation of regional support teams "in place" can begin without staff relocation.

Several comments noted that the "IHS has been downsized already" and oppose additional downsizing. One states "during the past 5 years, the IHS had already undergone massive restructuring downsizing, reassignments with decentralization, and transfers to Tribes. The impact of proposed staff reductions has a cumulative effect that poses increasing danger." The prior restructuring and downsizing of administrative functions at IHS headquarters and Area Offices is documented extensively in section 4, "Recent Reforms in IHS" which states "The IHS has achieved downsizing during the past 6-8 years and its administrative functions are now about as lean as can reasonably be expected." The final report also notes that "Timeliness and quality of administrative support services will erode further unless the IHS organizational structure and operational work processes are transformed to address declining resources and changing needs."

One comment included observations on advantages and disadvantages of the Commissioned Officers (CO) versus Civil Service (CS) employment systems. The RIW did not specifically analyze relative benefits of either

the CO or CS approach. However, recommendation 7.5 suggests a comprehensive reexamination of the workforce mix needed for Indian health.

One comment identified the "historical information in the report is its great strength." The final report retains explanation of core principles which are critical to Indian people and a description of poor health conditions and unmet needs in Indian Country. Members of the RIW believe that it is unwise to plan for the future without first examining the past.

There were several questions about the "affects on Tribal shares." At least one comment opposed consolidation with HHS because it would eliminate ability to track tribal shares. In section 5, subsection "Tribal Self-determination Rights", the reports states support for Tribal self-determination rights and recommended in 5.11 "Ensure that IHS reforms accommodate and affirm Tribal rights to compact, contract, or retain IHS to operate health programs directly." And in recommendation 5.12 "Track all realigned resources to ensure that resources available to the Tribes (known as Tribal shares) are not reduced as consequence of reforms."

There were several questions about "affects on Indian Preference." One comment stated "eliminating the authority for Indian Preference would harm Indian self-determination." Preservation of "Indian Preference" for the IHS workforce was one reason the RIW opposed transfer of FTE to HHS where preference could be lost. Section 5 includes the following reference: "The IHS operates under a unique law that applies Indian Preference in hiring and promotion practices. Sixty-nine percent of the IHS work force are members of federally recognized Tribes. Their diverse cultures and traditions create a unique work force and work environment."

One comment requested clarification of "performance contracts." Recommendation 5.3 states "The HHS should use performance contracts and inter-agency agreements to ensure accountability to the Secretary." The performance contracts refer to performance targets for the IHS during each fiscal year. The RIW believes that HHS restructuring goals can be accomplished with this mechanism rather than with organizational consolidation.

One comment suggested that information technology issues should be deferred to the national tribal/IHS Information Systems Advisory (ISAC). The RIW reviewed ISAC plans and endorses investment in technological infrastructure needed to adapt to changing conditions and needs expected during the next 5-7 years. The RIW agrees that the ISAC and Business Plan workgroups are better equipped to address technical details of IT plans.

Several comments expressed concerns and questions regarding urban Indian health organizations being given the same considerations/eligibility as Tribes. "Urban Indians are not designated in the report. Are Urban Health Programs included in all the recommendations?" The RIW members acknowledge the health care needs of tribal members living in urban areas and that Urban Indian projects are an important and severely under funded leg in the 3-leg I/T/U health care system. A representative from the National Council of Urban Indian Health was a member of the RIW and was present at most meetings. Throughout the final report the term "Indian health system" is used to avoid designating separate parts of the Indian health care system and to reinforce inclusiveness of all programs serving Indian people. Except for recommendations specifically addressing tribal governments regarding treaties, government-to-government, and sovereignty principles, etc., and except where authorizing legislation limits applicability to urban Indian health programs, all other RIW recommendations apply equally to all parts (I/T/U) of the Indian health care system.

One comment endorsed posting a "Patient Bill of Rights" in all I/T/U sites. Recommendation 2.14 in the final report states: "The IHS must clarify its Patient Bill of Rights to ensure both a high quality and level of services for American Indian and Alaska Native patients."

Several comments questioned "how Indian health fits into the President's management agenda?" Section 5, "One-HHS Proposals and the President's Management Agenda," explores this in detail. The final report identified

goals corresponding with President's agenda, but offers other means to achieve them. RIW recommendations insist that "savings" be reinvested into additional health services for Indian people.

One comment endorsed "standardization of data systems and protocols to assure that all locations work together." Section 8 in the final report, maintains a sub-section "Investment in Information Technology" and adds that technology and information infrastructure is essential to achieving the RIW vision for a stronger health care system nation-wide including implementation of regional support teams and other measures to improve support to the front line health delivery programs.

One comment noted that the Interim RIW report "makes numerous recommendations that are designed to accommodate the restructuring and expand health and human services to American Indians, protect tribal sovereignty, honor the government-to-government relationship, increase health care funding and not further erode federal services to Indian people." The final report reaffirms recommendations cited in this comment.

One comment noted "the report should focus on past IHS downsizing and compare it to other agencies." Another comment stated "Downsizing: the agency is at the point of implosion!" Section 4, "Recent Reforms in IHS," explores downsizing at IHS since 1995. Data on other HHS agencies is not available. Downsizing in IHS is one reason the RIW does not support further downsizing. However, the downsized administrative support system needs to improve performance. In section 8, "Internal Restructuring Reforms," the RIW concluded that neither the IHS administrative organizational structure nor its operational work practices have fully adapted to the reality of significantly less resources. Not adapting the system has resulted in degraded support to the front line programs. This is the primary justification for internal realignments of administrative functions.

One comment recommended "engineering positions in Dallas and Seattle be decentralized and sent to the Areas to directly work with the Areas and the Tribes." Recommendation 8.16 of the final report states "The RIW does not recommend further consolidation or dispersal at this time of engineering functions now located in Dallas and Seattle." However, members of the RIW believe that further study of this issue is appropriate especially in view the HHS proposal to consolidate HHS facilities programs in FY 2004.

Several comments endorsed ideas for Tribes and urban centers to increase access to opportunities for direct funding and grant eligibility including bio-terrorism resources. In Section 8, "Internal Restructuring Reforms," a new subsection "Investment to Access Resources" is included in the final report. It offers 8 new recommendations designed to assist Tribes and urban programs realize all resources for which they are eligible.

Several comments expressed questions, concern, and "unease" about the 51st state concept mentioned in Recommendation 2.5 which seeks expanded eligibility for grants and resources from other agencies by granting Tribes status as a 51st state. Some thought the term was confusing, raised unnecessary constitutional issues, and that the federal government could contract/grant directly with Tribes without designation as 51st state. Some want Tribes designated with "special status" other than as 51st state. Recommendation 2.5 was revised to read "The HHS Secretary must provide to Tribal Governments direct eligibility for HHS grants and access to funds from other HHS agencies that are normally reserved only for states..." The revision focuses on the desired outcome - eligibility for funds normally reserved for states - and avoids unnecessary constitutional questions.

Several comments opposed consolidation of IHS area offices. One comment "opposed regionalizing or physically relocating administrative functions" due to concerns about timeliness and responsiveness. In section 8, "Internal Restructuring Reforms," of the final report recommendation 8.3 states: "No IHS Area Office will close." Area offices will continue as a point of access for Tribes and will continue providing technical assistance to front line health care programs. While the mix of components at each Area office may vary overtime, all front line health care programs will have access to the full array of administrative support services from the combination of Area Office and regional center.

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⁴ Unpublished vital event data, 1996-98 (IHS Office of Public Health – Program Statistics). Vital event data will be published in Trends in Indian Health, 2000-01 edition. Vital event statistics are derived from data furnished annually to the IHS by the National Center for Health Statistics (NCHS).

⁵ Ibid.

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⁷ Sanitation Deficiency System (SDS) Data Base, FY 2001 (Unpublished Data). This water/sewer/solid waste projects database is maintained by the IHS but includes input from the Tribes/Tribal Organizations. Comparisons are with data published by the Environmental Protection Agency and the Census Bureau.

⁸ IHS appropriations and collections for personal health care services are included but not non-personal health services (\$582 per capita in 2001) or medical services outside IHS facilities. Buying power discounts expenditures by annual inflation.

⁹ Level of Need Funded Cost Model, LNF Workgroup Report to the IHS, 1999 – IHS website. The 1999 study used actuarial methods to compare Indian health funding with costs of a mainstream health insurance plan, the Federal Employees Health Benefits Plan. Updated 2001 data show the expected cost of enrolling Indians, which have poor health and higher costs, in such a FEHBP plan would cost \$3,582 per person. Approximately 25% of the plan cost would be offset by Medicare, Medicaid, and private insurance leaving a \$2,687 net cost. Currently, IHS expends \$2 billion out of \$2.8 billion for personal medical services—approximately \$1,475 per capital. Note that \$1,475 includes limited amount of expenditures not counted in the source material for technical reasons related to a resource allocation formula.

¹⁰ Sources: IHS appropriations and collections for personal health care services are included but not expenditures for non-personal health care services (\$582 per capita in 2001) or unknown payments for medical services provided to Indians outside IHS facilities. The U.S. average per capita health care expenditures projections were based on the 1999 version of the National Health Expenditures (NHE) study released in March 2001 (see Centers for Medicare and Medicaid Services web page). Buying power estimates were obtained by discounting expenditures by cumulative rates for medical inflation published by the Bureau of Labor Statistics.

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¹⁴The increase in cardiovascular disease is a consideration for future health disparities. The Indian death rates for cardiovascular disease are somewhat elevated compared to the rates for U.S. All Races. Indians died from diseases of the heart in 1994-96 at an age-adjusted rate 13 percent higher than that for the All Races population in 1995, i.e., 156 compared to 138.3.

¹⁵ Holding significance in many tribal cultures, this symbol, known as the "circle of life", "medicine wheel", and "hoop" has many variations. While the traditions vary from tribe to tribe, many share principles that life is like a circle, each part is connected to all other parts and all are part of a continuing whole. It can symbolize all people, animals, rocks, rivers and religions in an interconnected universe. The four directions can provide a symbolic road map for life using traditional Indian beliefs.